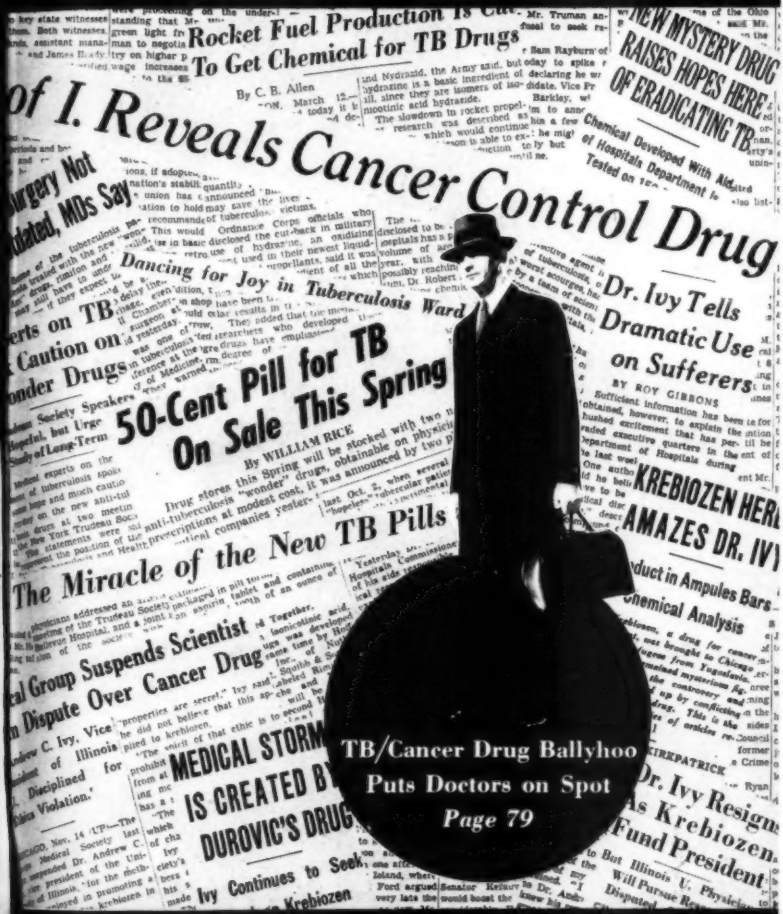
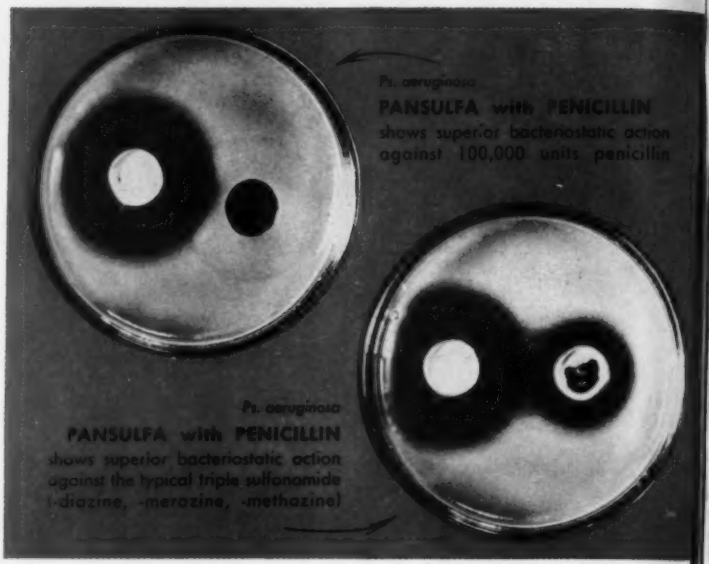
Medical Economics



TB/Cancer Drug Ballyhoo
Puts Doctors on Spot
Page 79



And the difference you can expect for patients is just as apparent

and another big difference... Sulfacetamide is the least toxic sulfonamide reported in Lehr's clinical studies.* Naturally, that eases your mind about possible toxic effect . . . lessens danger of crystalluria or renal damage.

PANSULFA with PENICILLIN

Each tablet contains:

Crystalline Penicillin Potassium G	100,000 units
Sulfamerazine	0.167 Gm.
Sulfadiazine	0.167 Gm.
Sulfacetamide	0.167 Gm.

Also **PANSULFA** (Sulfacetamide - Sulfamerazine - Sulfadiazine)
SUSPENSION • TABLETS

Merrell
1828
CINCINNATI
New York • Toronto

*See Lehr, D., N. Y. St. J. Med. 11:1361, 1950

Trade-mark "Pansulfa"

WHAT DO YOU LOOK FOR IN A PARENTERAL PRODUCT?

Every ULMER Injectable, like each other ULMER product, is carefully assayed before release. It *must* be full potency, with an added "bonus" quantity to insure full potency during the entire shelf life of the product. In addition, each vial is checked for sterility by a "quarantine" period after manufacture. When you order ULMER Injectables you *know* you are getting the finest quality products available, regardless of price. As an extra incentive, ULMER Injectables are priced *right* for the economy minded purchaser. You can buy no better products than ULMER Injectables, with guaranteed sterility, guaranteed potency and guaranteed purity.

Write today for the 1952 price list of ULMER Injectables. It's free.

Two new items from the ULMER Injectable Line:

ESOPRINE "Ulmer" #2000
A new product for control of muscle spasm. Contains physostigmine and homatropine. 10 cc vials.

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An aqueous suspension containing, per cc. natural estrogenic substances 2.5 mg. and progesterone U.S.P. 25 mg. 10 cc vials.

PHYSICIANS AND HOSPITALS SUPPLY CO., Inc.
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RAISE HEMOGLOBIN LEVELS TO HEALTHFUL NORMS . . . *IN DAYS*

WITH

HEMATOVALS "Ulmer"

SOFT, SOLUBLE CAPSULE

FAST-ACTING LIQUID CENTER

IRON+LIVER+B-COMPLEX

RAPID, SUSTAINED EFFECT

Pleasantly flavored HEMA-LIQUID "Ulmer" is recommended for children. One teaspoon is approximately equal to one Hematoval "Ulmer".

HEMATOVALS "Ulmer" are soft elastic capsules of Iron, Liver and Vitamin B-complex. Their semi-liquid contents are more readily absorbed and assimilated with less iron irritation.

The iron in HEMATOVALS "Ulmer", ferrous sulfate in an ionic state, is the iron of choice with leading internists in treating secondary anemias.

Doctors agree that a patient on HEMATOVALS "Ulmer" rarely experiences discomfort. Intolerance is minimized by the contents of the ova diffusing rapidly with the stomach fluids and quickly passing into the duodenum . . . welcome contrast to the astringent, dry forms of iron.

HEMATOVALS "Ulmer" provide excellent and rapid aid in the restoration of hemoglobin levels in post-operative cases and are especially indicated in the more stubborn cases of secondary anemia.

The recommended daily dose of two HEMATOVALS "Ulmer" three times a day not only supplies the necessary amounts of readily assimilated iron, but also affords liver (secondary fraction) and supplies effective amounts of B-complex.

SEND TODAY!

Please send me sample and folder on HEMATOVALS "Ulmer" ME-552B.

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RADIANT HEALTH

results from

POSITIVE PRENATAL PROTECTION

With ULVICAL "Ulmer" you will obtain *consistent* maximum utilization of the dietary elements necessary for prenatal care of mother and child. With ULVICAL "Ulmer" you will gain a complete patient acceptance.

ULVICAL "Ulmer" tablets are uniquely fabricated to release each component at its own point of maximum utilization *and maximum tolerance.* Rarely will you find a patient who cannot take these small white tablets with complete comfort and safety. In fact, although ULVICAL "Ulmer" tablets should be taken three times a day for best efficiency, in most cases a complete day's dosage could be taken at one time without intolerance

ULVICAL "Ulmer" with its complete acceptance is the most economical dietary supplement you can prescribe.

Recommended dosage:
One or two tablets
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Each tablet contains:

Vitamin A	1500 USP units
Vitamin D (irradiated ergosterol)	200 USP units
Thiamine HCl	1 mg.
Riboflavin	2 mg.
Ascorbic Acid	16.66 mg.
Alpha Tocopherol (from mixed tocopherols)	2 mg.
Calcium Pyrophosphate supplies 900 mg. Calcium 720 mg. Phosphorus	7.5 gr.
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ME-552C

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Medical Economics

* * * *May 1952* * * *

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Contents [*Continued*]

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Rapid response plus virtual absence of allergic reactions or organism resistance mark topical treatment of Gram-positive infections of eye or skin with

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500 units per Gm.

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Pfizer *the world's largest producer of antibiotics*

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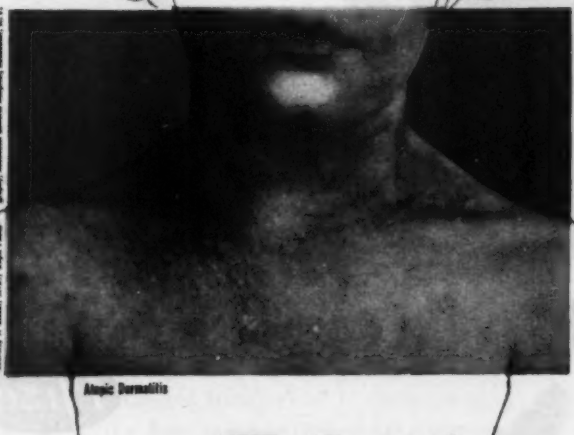
eczema...



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Atopic Dermatitis

Vioform

CREAM

"..... has proved to be the topical answer to eczema when orthodox treatment ... has failed."[1]

1. *Perlman, H. H.: J. Pediat. 33: 114, 19*

Ciba PHARMACEUTICAL PRODUCTS, INC., SUMMIT, NEW

VIOFORM® (IODOCHLORHYDROXYQUIN)

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For flexible oral penicillin dosage

Oral Suspension BICILLIN has the advantage of permitting flexible dosage. If you wish to write smaller dosages of penicillin than 300 mg. (300,000 units) per teaspoonful, use these simple prescriptions:

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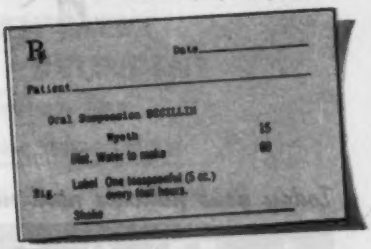
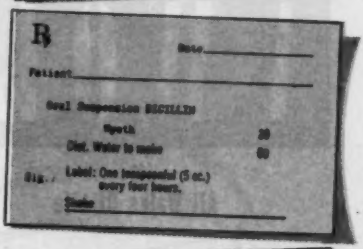
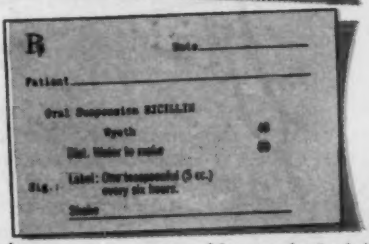


100,000 units *prescribe*



200,000 units *prescribe*



clinically effective . . . stable . . . unusually palatable

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formula: Each teaspoonful (5 cc.) of BICILLIN provides approximately 300 mg. (300,000 units) N,N¹-dibenzylethylenediamine dipenicillin G in a flavored, aqueous syrup base. Available in bottles of 2 fl. oz.

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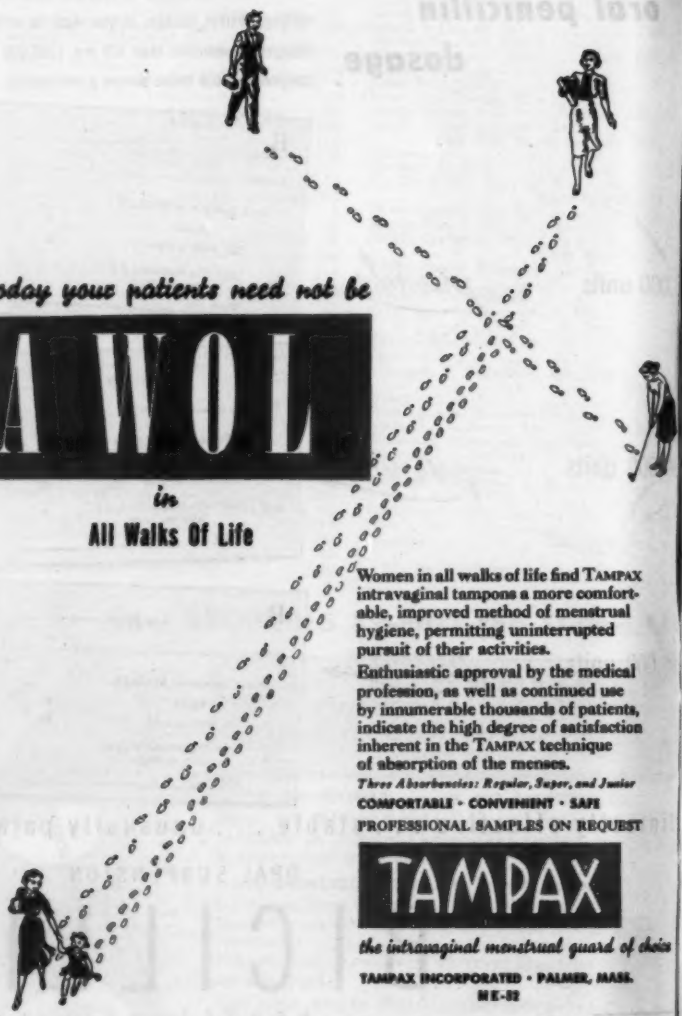

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All Walks Of Life

Women in all walks of life find TAMPAX intravaginal tampons a more comfortable, improved method of menstrual hygiene, permitting uninterrupted pursuit of their activities.

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In Para-Nasal Infection **ARGYROL** Provides

BACTERIOSTATIC
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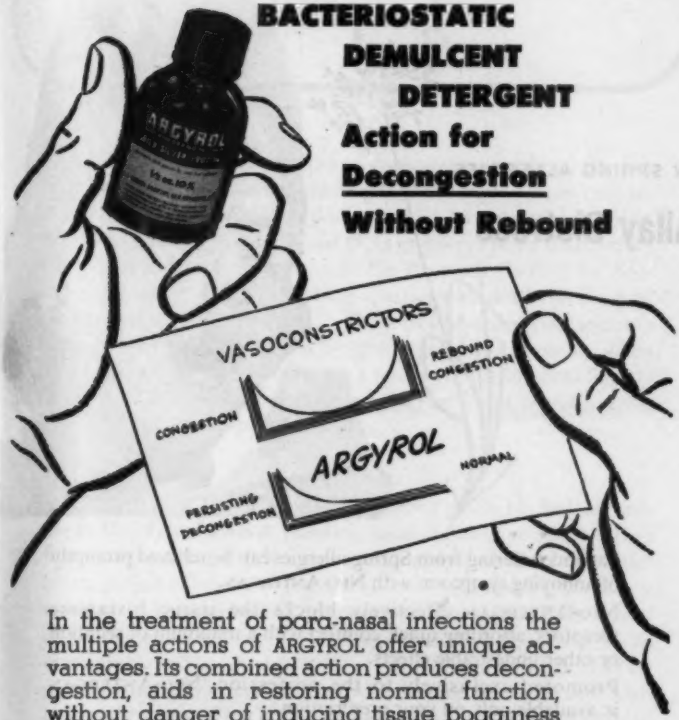
DETERGENT
Action for **Decongestion**
Without Rebound



In the treatment of para-nasal infections the multiple actions of ARGYROL offer unique advantages. Its combined action produces decongestion, aids in restoring normal function, without danger of inducing tissue bogginess and Rhinitis Medicamentosa.

The ARGYROL Technique

1. The nasal meatus . . . by 20 per cent ARGYROL instillations through the nasolacrimal duct.
2. The nasal passages . . . with 10 per cent ARGYROL solution in drops.
3. The nasal cavities . . . with 10 per cent ARGYROL by nasal tamponage.

Its Three-Fold Effect

1. Decongests without irritation to the membrane and without ciliary injury.
2. Definitely bacteriostatic, yet non-toxic to tissue.
3. Stimulates secretion and cleanses, thereby enhancing Nature's own first line of defense.

—the medication of choice in treating para-nasal infection.

Decongestion and Relief Without Rebound

Decongestion Without Dysfunction

Specify the Original **ARGYROL** Package

Made only by the

A. C. BARNES COMPANY, NEW BRUNSWICK, N. J.

IN SPRING ALLERGIES...

Allay Distress

Patients suffering from Spring allergies can be relieved promptly of annoying symptoms with NEO-ANTERGAN.

NEO-ANTERGAN effectively blocks the tissue histamine receptors, affording quick comfort with a minimum of sedation or other undesirable effects.

Promoted exclusively to the profession, NEO-ANTERGAN is available only on your prescription.

Your local pharmacy stocks NEO-ANTERGAN Maleate in 25 and 50 mg. coated tablets in bottles of 100, 500, and 1,000.

The Physician's Product

Neo-Antergan®

MALEATE

(Pyrilamine Maleate)

COUNCIL ACCEPTED

Research and Production for the Nation's Health

MERCK & CO., INC.
Manufacturing Chemists
RAHWAY, NEW JERSEY

Panorama

With prices going up everywhere, the San Francisco Medical Society points pridefully to its 14 per cent reduction in dues—from $35 to $30 a year . . . An industrial company can expect from 3 to 6 per cent of its employes to be disabled by prolonged illness every year, says the Research Council for Economic Security, which is making a nationwide study of the economic effects of such illnesses . . . Do you overburden your society's emergency telephone bureau by giving patients its number when you take time off? The Onondaga County (N.Y.) Medical Society suggests that it is "more logical and efficient" for a doctor to have his practice covered by a colleague.

Young M.D.'s aren't easily bluffed, according to Maj. Gen. Lewis B. Hershey, head of Selective Service. He's told Congress that it takes an average of twenty-five letters and phone calls to "frighten" one doctor into volunteering for Army service . . . Department of Strange Bedfellows: The Yale School of Medicine has organized a marriage clinic to be operated by its gynecologic and psychiatric staffs . . . Blue Shield now has 114,000 participating physicians—88,000 with service plans, 26,000 with indemnity plans. That's 87 per cent of all privately practicing M.D.'s in Blue Shield-serviced areas . . . Doctor's day off continues to be a problem in Michigan. The state medical society is urging M.D.'s "to stagger their half-holidays"—especially in small towns.

There's still life in the old gray nightmare: A bill before the New York legislature would impose compulsory health insurance on the state's 14 million people, with employers and workers splitting a 3 per cent tax on salaries up to $4,800 a year . . . Charging he was unjustly committed to a mental hospital on the basis of a "perfunctory physical examination," Dale D.

Sheets, 50, has sued Dr. Paul Van Kirk of Frankfort, Ind., for $150,000 . . . A Dallas, Tex., doctor who allegedly wrote barbiturate prescriptions for a non-existent woman—and then masqueraded as a woman to have them filled—posed a problem for arresting officers: What law, if any, had he broken? . . . Nineteen of the fifty-four biggest life insurance companies and twenty of the 100 largest industrial corporations have contributed to the National Fund for Medical Education, thus reaffirming their belief that U.S. business has a stake in medicine.

Questionnaires sent out by the Queens County (N.Y.) medical society ask members for frank appraisal of its meetings—good and bad points—as well as suggestions for improving them . . . That's gratitude: An apparently dead woman, "brought back to life" by municipal physicians in San Francisco, has sued the city, asserting that the emergency treatment caused burns . . . Do you read backwards? The Rhode Island Medical Journal justifies its new practice of printing summaries at the beginnings of scientific papers on the ground that summaries are what doctors read first . . . Hollywood is making a film based on the Korean exploit of Brig. Gen. Crawford E. Sams. Suspecting that the Reds had a bubonic plague epidemic on their hands, he led a foray behind their lines and got prisoners for a checkup.

Fat people should be required to pay higher-than-ordinary rates for hospitalization insurance, Drs. Bent Krarup and C. J. Schwenson believe. These Danish doctors say they've made a 2-year survey which proves that fat patients average five days more than ordinary people in the hospital. Since obesity is usually due to carelessness, they conclude, it's only fair that obese patients pay premium rates . . . Pediatricians are weighing the possibilities of canned fresh whole milk, now becoming increasingly available. It's taken from cows, then pasteurized, homogenized, and canned—all without coming into contact with air—and its low bacterial content is said to assure freshness for months . . . Department of Nothing's Ever Perfect: The title "grievance committee" may in itself suggest to patients that they have a grievance and thus inspire complaints, says the Kentucky State Medical Association. It prefers "professional relations committee."

Reasons for effectiveness of Furacin

A wide antibacterial spectrum, including many gram-negative and gram-positive organisms • Effectiveness in the presence of wound exudates • Lack of cytotoxicity: no interference with healing or phagocytosis • Low incidence of sensitization: less than 5% • Ability to minimize malodor of infected lesions • Stability. Furacin® preparations contain Furacin 0.2% brand of nitrofurazone N.N.R. in water-miscible vehicles which dissolve in exudates.

IN CHRONIC VARICOSE ULCERS...

In a female aged 47 years, varicose ulcers had proven refractory to rest, elevation of the leg, compresses and diverse topical applications. There was profuse discharge with Micrococcus pyogenes aureus, Streptococcus pyogenes, P. aeruginosa (pyocyaneus) *(Fig. 1).*

October 15. Furacin Soluble Dressing applied. There was rapid diminution in drainage. The ulcers soon showed a clean, granulating surface.

December 10. Linton skin flap operation performed. Furacin Soluble Dressing used postoperatively.

February 26. Patient discharged *(Fig. 2);* complete healing two weeks later.

Literature on request.

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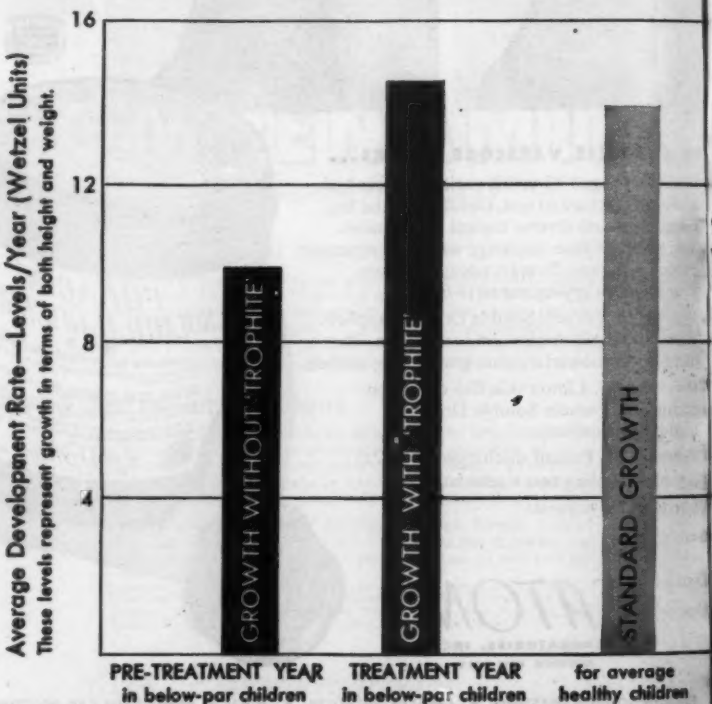
TROPHITE*

a delicious, high-potency elixir of B_{12} and B_1 to incre petit

See how 'Trophite' increases growth

In a controlled clinical trial—over a one-year period—'Trophite' produced almost a 50% increase in rate of growth in children who had be below par. (For details, see professional literature.)



Troph
When
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Each 5
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petite and growth

Trophite' increases appetite

When growing children lose appetite because of B_{12} or B_1 deficiency, 'Trophite' increases appetite by insuring adequate intake of both these factors.

Trophite' is delicious

'Trophite' is not merely palatable; *it is delicious.* During the clinical tials, virtually every one of the hundreds of child patients expressed actual delight in taking 'Trophite'.

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Your patients who "can't seem to relax"—who feel tense and anxious yet have no organic basis for their disturbance—may be promptly relieved by prescribing Oranixon, the first Council-accepted brand of mephenesin. Oranixon will relax these patients without "doping" them. You will find that two or three 500-mg tablets daily usually suffice to keep these patients pleasantly and comfortably at ease. Try Oranixon as well for some of your patients whose mentality and motor functions are "imprisoned" by hyperactive reflexes. Oranixon is available in 250-mg and 500-mg oral tablets (specially compounded for rapid disintegration and full activity) and in an elixir containing 400 mg of mephenesin per teaspoonful.

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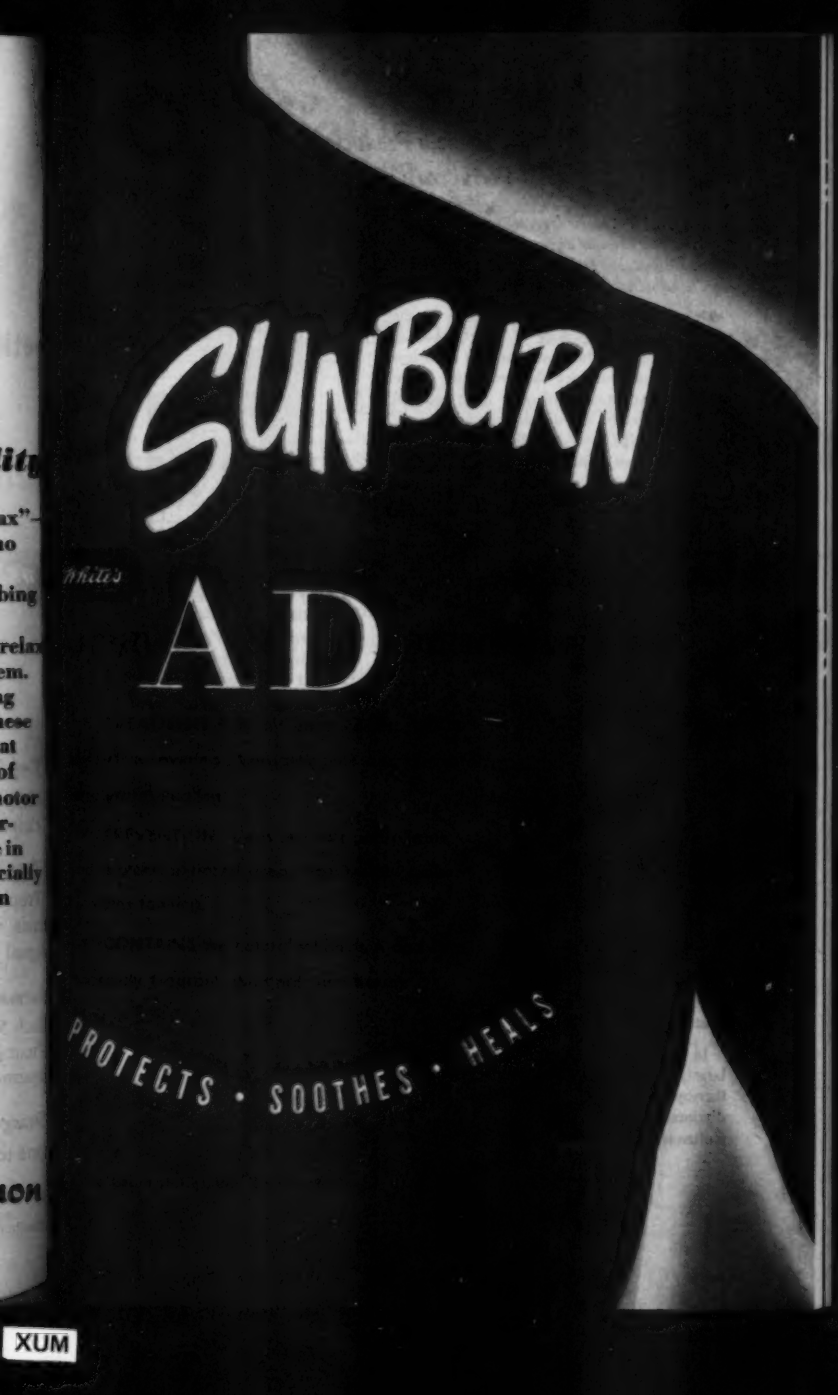
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PROTECTS • SOOTHES • HEALS

Hydergine — A New Product and New Approach To Peripheral Vascular Diseases

Investigation of a new approach to the treatment of peripheral vascular diseases and hypertension has established the practical value of hydrogenated ergot alkaloids.

Development of these alkaloids in the Sandoz Laboratories, study of their properties and evaluation of their usefulness by clinicians are the groundwork for the therapeutic application of Hydergine. Hydergine is an equiproportional mixture of dihydroergocornine, dihydroergocristine and dihydroergokryptine as methanesulfonates. These substances are produced by hydrogenation of several naturally-occurring alkaloids which comprise the ergotoxine group.*

Pharmacology and Therapeutics: The exceptional value of Hydergine in vascular diseases rests on its ability to attack these diseases through several actions. Lowering of peripheral resistance and vasodilatation result from an interplay of both central and peripheral actions:

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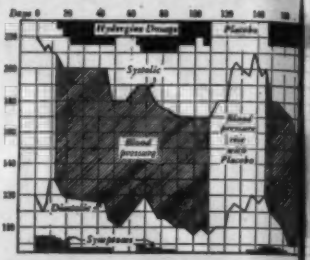
By reason of the latter action Hydergine is *free of the disadvantage which characterizes other adrenergic blocking agents,* namely the increase in heart rate which accompanies the administration of the latter agents.

In therapy of hypertension and/or vascular disease Hydergine affords a frank drop in blood pressure, relief of subjective symptoms and improvement of peripheral and coronary circulation; the slowing of heart rate allows more efficient diastolic filling

In some hypertensives the benefit obtained is largely from improvement of cerebral blood flow, thereby relieving subjective symptoms (tinnitus, dizziness, headache, visual disturbances etc.). This is often as important as a reduction of blood pressure.

Specific Indications: Hypertension; Raynaud's disease, acrocyanosis, frostbite; Buerger's disease, thrombophlebitis, arteriosclerosis obliterans.



Dosage and Administration:

Peripheral vascular disease: 1 to 2 cc. i.m. or every other day, according to need. Continue medication until clinical evidence of improvement

Hypertension: First — preliminary injection test is given to determine what degree of therapeutic effect can be expected in the particular patient.

Procedure: have patient recline for 30 minutes, take a basic B.P. reading; inject 1 cc. Hydergine i.m. and note the degree and duration of drop in B.P. Marked response, lasting for several hours is a sign of labile hypertension; a lesser response may indicate need for higher therapeutic dosage.

Therapeutic Dosage: if the test showed good response, start with 1 cc. i.m. 3 times per week. If test repsonse was slight, start with 1 to 2 cc. every one to two days. Dosage must be adjusted upward as necessary for each patient to obtain the optimum maintenance effect.

Form Available: Ampuls 1 cc., containing 0.3 mg. Hydergine.

*This term is no longer justified for these substances, since the chemical studies by Stoll have uncovered them as true alkaloids (ergocornine, ergocristine and ergokryptine).

GENERAL REFERENCES:

1. NICKERSON, M.: J. Pharmacol. & Exper. Therap. 91: 1949. 2. STOLL, A. and HOFMANN, A.: Helvet. chim. acta 26: 1570, 1943; ibid. 2070, 1943. 3. ROTHLIN, E.: Helvet. physiol. acta 2: C 48, 1944. 4. ORTH, O. ET AL.: Federation Proc. 361, 1947. 5. FREIS, E. ET AL.: Am. J. M. Sc. 216: 165, 1948. 6. BLUNTSCHLI, H. and GOETZ, R.: Am. Heart J. 35: 1948. 7. POPKIN, R.: California Med. 72: 108, 1950. JOSEPHS, L.: Am. Pract. 4: 71, 1949.

For details on Clinical Applications request brochure; address:

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68 CHARLTON STREET, NEW YORK 14, N. Y.

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SKOLEX

SUN ALLERGY CREAM

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Two years of testing by doctors confirm that Skolex Sun Allergy Cream is virtually impenetrable to wave lengths 2900 to 3200 A.U.—the region in the spectrum most responsible for sunburn and other skin reactions to ultraviolet rays.

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Vanishing cream type base is also helpful in dry skin conditions often associated with sun sensitivities.

ACTIVE INGREDIENT:

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BASE: Stearic Acid, Cetyl Alcohol, Petrolatum, Hydroxybenzoate, Triethanolamine, Carbowax, Perfume (nonirritant), Water.

Samples are available for your clinical use. Write Dept. ME 1 The J. B. Williams Company, Glastonbury, or use coupon below.

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Please send me samples of Skolex for clinical use.

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1. Carnation constantly improves the raw milk supply. Cattle from champion Carnation bloodlines are shipped to farmers to improve the milk supplied to Carnation plants.

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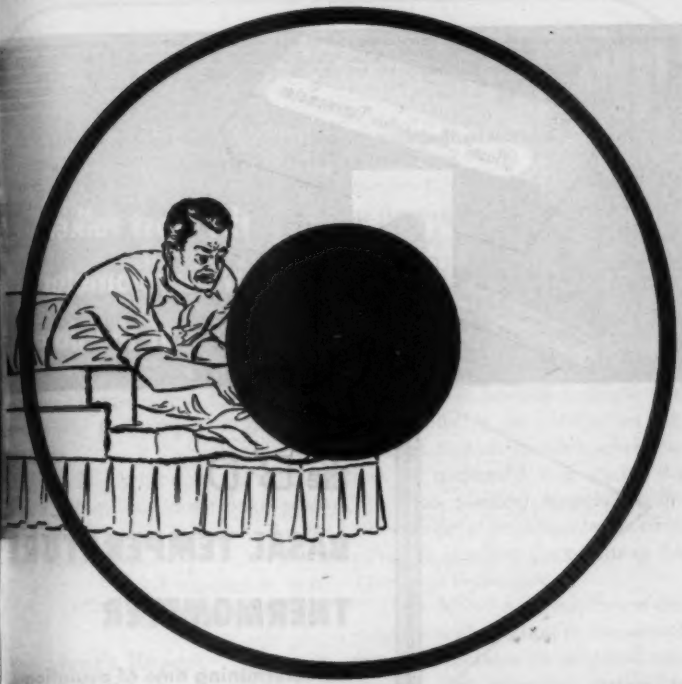
4. Carnation Milk is available everywhere.

5. Carnation quality control continues even AFTER the milk leaves the plant, through frequent inspection of dealers' stocks.

"The Milk Every Doctor Knows"

"from Contented Cows"



To obtain a specific response in GOUT and GOUTY ARTHRITIS

NEOCYLATE
TRADEMARK

with COLCHICINE

Another Central First

Each NEOCYLATE* with COLCHICINE Enteb* contains:

Sodium Salicylate . 0.25 Gm. (4 gr.)
Para-Aminobenzoic Acid .... 0.25 Gm. (4 gr.)
Ascorbic Acid ..... 20.00 mg. (1/3 gr.)
Colchicine ..... 0.25 mg. (1/250 gr.)

SUPPLIED: Bottles of 200, 500, and 1000 Enteb.

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Speaking Frankly

Deduction

Sirs: I have long been puzzled by a strange fact. The Bureau of Internal Revenue allows us to deduct the cost of attendance at medical conventions as a professional expense. Yet it will not permit an income tax deduction for the outlays made in taking post-graduate courses.

I have finally hit upon the explanation: Politicians don't take post-graduate courses, but they do attend conventions.

Lyon Steine, M.D.
Valley Stream, N.Y.

President's Report

Sirs: Under the heading of "Information, Please" [February, 1952], you call attention to [three] announcements of programs or policies of the American Medical Association concerning which you lack information and desire it.

The first concerns the proposed [A.M.A.] survey of the health facilities and health needs of this country. In June, 1949, the Coordinating Committee for the National Education Campaign recommended to the Board of Trustees that such a survey be undertaken. The Board of Trustees approved this recommendation. But while the program was in the preliminary planning stage, the Brookings Institution of Washington, D.C., came to the American Medical Association, asking its assistance in the conduct of a similar survey.

The Brookings Institution enjoys a reputation for thoroughness and impartiality. In view of the fact that an organization of such character was to undertake this study, the American Medical Association decided to defer implementation of its program, pending the results of the Brookings investigation.

There have been a number of discussions with relation to the second item you mention [a proposed conference with consumer groups, to consider the A.M.A. program "and such elaboration as may seem indicated in the public interest"]. Numerous conferences have been held with various groups representing widely divergent interests in the field of medical care. This item is still under consideration by the Board of Trustees.

The third item you mention—the establishment of a committee of prominent laymen to advise the Board of Trustees—is still under consideration. Alternative plans have been suggested, but no decision as

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to the exact method has been reached by the Board of Trustees.

John W. Cline, M.D., President
American Medical Association
San Francisco, Calif.

Our thanks to Dr. Cline for this interim report on three major A.M.A. projects that had been lost to view. Such reports, in our opinion, would be welcomed from time to time by A.M.A. delegates and others interested in medicine's progress. This, in fact, was the point of our February comment.

Fee Splitting

SIRS: The time has come for general practitioners to rebel about the barrage of insinuations against fee splitting laid down by specialists. The issue *should* be the exorbitant fees some specialists charge. Fee splitting should not be used as a cover-up for their fee-gouging.

The latest smear technique is to use fee splitting and ghost surgery as synonyms. Ghost surgery is deceitful and dishonest; it should be eliminated. Fee splitting, on the other hand, is as honorable and moral as our American tradition of free enterprise.

The general practitioner, after all, frequently acts as coordinator between patient and specialist. He's like the general contractor in the building field; he's not just the "pointer dog" some elite specialists make him out to be.

As a medical coordinator, the G.P. is responsible for choosing the consultants and surgeons his patient needs. After proper investigation he should make an estimate of all fees —including a percentage for his services. This estimate should be itemized and sent to the patient.

If this procedure were given half a chance, the current ugly inference of the term "fee splitting" would vanish. More important, the ruthless minority of specialist fee gougers would be exposed.

M.D., Illinois

Calumny in Court

SIRS: Adverse publicity given the physician during the past few years seems to have made its mark not only on the unsuspecting average citizen but even in relatively high places. Take my recent experience:

Not long ago, I was asked by the district attorney here to testify in court. On the day of the hearing, I was unavoidably delayed because of an emergency call, and I arrived in court fifteen minutes late. Thereupon the judge gave me quite a lecture, lashing at me in front of the court as though I were a school boy in serious wrong. He charged me with contempt of court and refused to listen to my reason for being late. I was ordered to report two days later, prepared to defend myself. I was told that the charge I faced might mean five years in prison.

Two days later, after canceling my afternoon appointments at the office, I was preparing to leave for

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Blakey, P. R.: Canad. M.A.J. 66:151 (Feb.) 1952.

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Acute bronchitis • Laryngotracheitis
Tracheobronchitis • Sinusitis
Chronic bronchiectasis
Pulmonary infections associated with pancreatic insufficiency
Scarlet fever • Urinary tract infections
Acute and subacute purulent conjunctivitis
Acute catarrhal conjunctivitis
Chronic blepharoconjunctivitis not involving the meibomian gland
Abscesses • Cellulitis
Furunculosis • Impetigo
Infections secondary to Acne vulgaris
Erysipelas • Peritonitis

GRAM-NEGATIVE BACTERIAL INFECTIONS

Gonorrhea • Brucellosis
Bacteremia and septicemia
Friedländer's pneumonia
Mixed bacterial pneumonias
Pertussis • Diffuse bronchopneumonia
Post-partum endometritis • Granuloma inguinale
Dysentery • Urinary tract infections
Respiratory tract infections
Cellulitis • Peritonitis • Tularemia

SPIROCHETAL INFECTIONS

Syphilis • Yaws • Vincent's infection

RICKETTSIAL INFECTIONS

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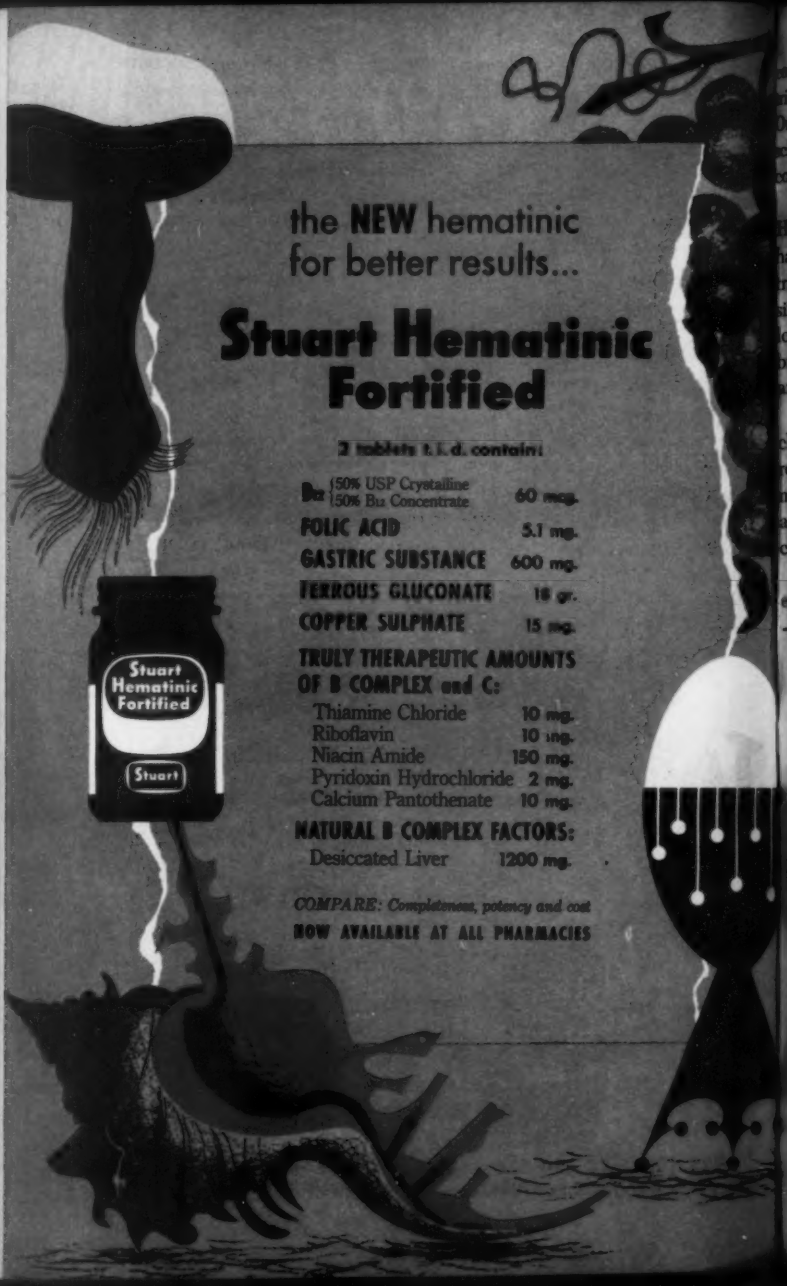
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court when I was advised that my trial had been postponed for a week. One week later, after canceling my scheduled surgery, I appeared at the courthouse with my counsel.

This time I was told that His Honor had investigated the law and had found that I would have to be tried by the district attorney. But since I had been testifying for the local D.A., it would be necessary to bring the district attorney from another city to prosecute my case.

Finally, I went to the judge's chamber and pleaded that I had already lost considerable time from my work and could ill afford to lose any more. The judge dropped the charge.

This annoying and embarrassing experience has made me realize the influence of the court and the power it can bring to bear even in insignificant matters. These incidents do not build good relations between the legal and medical professions.

Reed S. Clegg, M.D.
Salt Lake City, Utah

Come the Depression

SINS: We are drifting toward some type of controlled medicine, whether we like it or not. What's the reason for this?

Homo Americanus, loaded down with worldly possessions and caught in an avalanche of constant buying, has created an artificial prosperity. He is so busy maintaining his accustomed luxury that he has no place in his budget (if any) for necessities. Years ago, there was a little

item in every budget called "doctor bills." There's no such item any more.

I am certain that in a sizable depression—which is not impossible—our profession as a private enterprise will be swept away. And it will be the first free-enterprise profession to suffer this fate.

Eugene F. Kalman, M.D.
Bridgeport, Conn.

For Specialists Only

SIRS: I've just been rereading "Goodbye to Group Practice" [November, 1951] and have decided that it should not go unanswered. It's easy to sympathize with the disillusionment of the writer in his two unfortunate experiences in groups, and his decision to resign is admirable. Yet his wholesale condemnation of group practice is comparable to a wholesale condemnation of democracy because of some of its corruption.

Commercialization of the group idea for the profit motive does occur, and the term "big-business group" is quite descriptive of a certain type. Obviously, it was this type with which the writer of your article was unfortunate enough to be associated.

Yet, despite such abuses, the group idea itself remains valid. Group practice is the direct result of specialization. Because of this specialization, expert opinion in more than one field is increasingly necessary in diagnosis. The function of the group is to coordinate the services of the specialists.

Thus, the membership of a group

should be confined to specialists. The inclusion of a general practitioner in a group creates a couple of insuperable problems: (a) defining the G.P.'s professional competence in the fields of obstetrics, pediatrics, and surgery; and (b) deciding upon a fair rate of pay for him.

The presence of a general practitioner in a group is likely to be viewed by other G.P.'s in the area as an attempt at monopoly. In fact, the group general practitioner is responsible for most of the antagonism that arises between group and non-group physicians. It follows, then, that the inclusion of a general practitioner definitely limits the group's sources of reference.

The function of the G.P. is family care, and he is irreplaceable in this respect. To fulfill his function, he must have proper tools, of which the group can furnish a very important one: namely, coordinated, readily available specialist services. This, I think, is the proper set-up—the general practitioner on one hand, the specialist group on the other. The two should not be combined, should not compete, but should complement each other.

The development of group practice for the care of private patients is the outstanding accomplishment of American medicine. Prostitution of the group idea, such as the writer of "Goodbye to Group Practice" describes, cannot survive because good men will not tolerate it.

C. S. Dickson, M.D.
Utica, N.Y.

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2. Surgeon beginning the operation.

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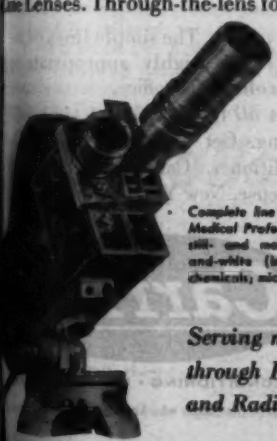

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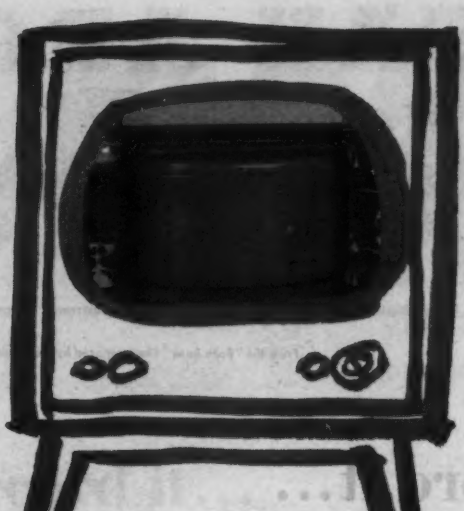

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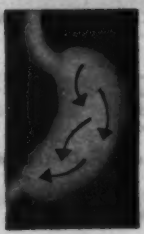

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Dosage: 1 tablet ½ hour before meals, three times daily, for the vagotonic type. Increase this dose, if necessary, to achieve the desired clinical result. ½ tablet ½ hour before meals, three times daily, for one week for the sympathicotonic type. If no signs of intolerance develop, increase this to 1 tablet. Supplied in bottles of 100 and 1000 scored tablets.

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All the essential vitamins which remain stable in solution are in one bottle. Another contains a powder consisting of those vitamins which best retain their stability when kept dry. Simply instruct that the liquid be added to the powder. Make sure. Put babies on 'Vi-Mix Drops.

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Sidelights

Look Before You Lease

Dozens of small towns these days are offering unprecedented enticements to doctors. So it's not surprising that more than a few M.D.'s are moving to the country. Trouble is, some of these medical migrants seem to be leaving common sense behind. This shows up particularly in the lease difficulties they get into.

For one young physician, the trouble started when he answered an ad that read something like this: "Town of Hinterland; trading center for population of 2,500; only doctor about to retire; wonderful opportunity; write Chamber of Commerce." He wrote; he investigated; he decided the opportunity *did* look wonderful. So he signed a five-year lease and moved in.

Then what? Let our young friend tell it:

"A year has elapsed, and the old doctor shows no signs of giving up practice. Worse yet, his former partner has been released from the Army and is back in town. Three-quarters of the people go to the old doctor, and most of the others go to the former medical officer. I simply can't make a living here.

"During the last war, my wife's cousin was allowed to break a lease on his service station. He couldn't get gasoline to sell, so he successfully invoked the doctrine of 'economic frustration.' Can't I get out of my lease in the same way—or do I have to join the Army?"

The truth is, neither economic frustration nor military duty can get this young doctor off the hook. He may be able to arrange a compromise settlement with his landlord; but otherwise he's legally committed to his five-year lease.

How to avoid this sort of trap? Make sure that there's an escape clause in your lease. It may cost you one to three months' extra rent if you move away for professional reasons; but it can spare you from a prolonged sentence to an economic dead end.

Waiter's Revenge

What would you do if *you* were a patient, and the doctor—apparently through poor office management—made you wait a couple of hours to see him? How would you, almost instinctively, pay the doctor back in kind?

In case the answer eludes you, we refer you to a revealing incident in Detroit. In several medical offices there, it's customary to affix the fol-

lowing sticker to outgoing bills that are three or four months past due:

YOUR REQUEST FOR CREDIT
WAS NOT IGNORED;
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SHOULD NOT BE.

Just recently, one delinquent debtor responded to this notice with a curt note reading thus:

"No, my request for credit was ignored. But some of my 3 o'clock appointments sure as hell were ignored until 4:30 or 5. So if *I* can wait, I guess it won't hurt *you*."

Time is money, the old saying goes. Or, to bring it up to date: If we waste the patient's time, it can cost *us* money.

Too Much Insurance

You won't hear this from many insurance agents, but it's a fact: Quite a few older physicians today are carrying more life insurance than they need.

The prime purpose of life insurance, after all, is to replace the economic value of your life to your dependents. This calls for lots of insurance—sometimes all you can carry—through your middle years. But what about after that?

Have your children become self-supporting? Is your house finally paid for? Have you reached the last decade of your productive career? In any of these circumstances, what you are likely to need is *less* life insurance, not more.

Yet too few doctors reduce their insurance coverage when they reach

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The *menopausal lipotropic*, MENOTROPE corrects the *interrelated* lipid and estrogenic imbalances of the menopause by providing a selected group of *interrelated* lipotropic agents esssential to liver function and the utilization of estrogens.

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these milestones. Some, under pressure from patients who sell insurance, even buy more. This results in stiff premium commitments that can keep an older practitioner from slowing down and enjoying life.

Sure, you want to build up an estate. But life insurance is only one means toward that end. Its more important function is to protect your dependents in the event of your death. And they need less protection of this sort as you move over to the shady side of 55.

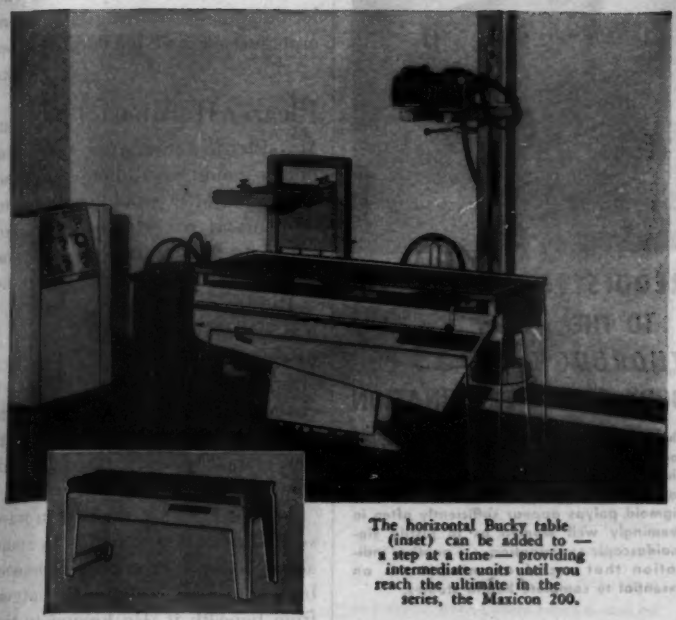
Threadbare Threat

It's about time we showed some restraint in using the following threat: "... or else we'll get socialized medicine."

We've heard this warning appended to exhortations that we support voluntary health insurance; that we be nicer to patients or do more charity work; explain our fees in advance; enlist in the night-call brigade; discipline the black sheep in our profession; spend more money for public relations.

All fair enough. But now comes Gen. George C. Kenney with a statement that unless we solve the problem of arthritis (by contributing to the foundation he heads) "we'll get socialized medicine."

That does it! Any day now, we'll be hearing of the same horrible fate in store for us if we don't provide an instant cure for teen-age pimples. Or if we don't hang canaries in our reception rooms. Or if we drive any car more modern than a 1931 Hup-



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My sister-in-law concedes that a doctor should have a hobby, but she wishes *her* M.D. would confine it to off-hours. Here's what actually happened to her the other day in La Crosse, Wis.:

During a routine office visit, she was describing certain digestive troubles. Her doctor, while listening sympathetically, swung his swivel chair idly through wide arcs. Suddenly, as one of his swings carried him around toward the window, he froze in place.

My sister-in-law stopped in midsentence and watched with some alarm as the doctor turned sharply back to his desk and drew a shotgun from beneath it. He lunged to the window, threw it open, and fired. As the roar died away, he grinned triumphantly and resumed his seat.

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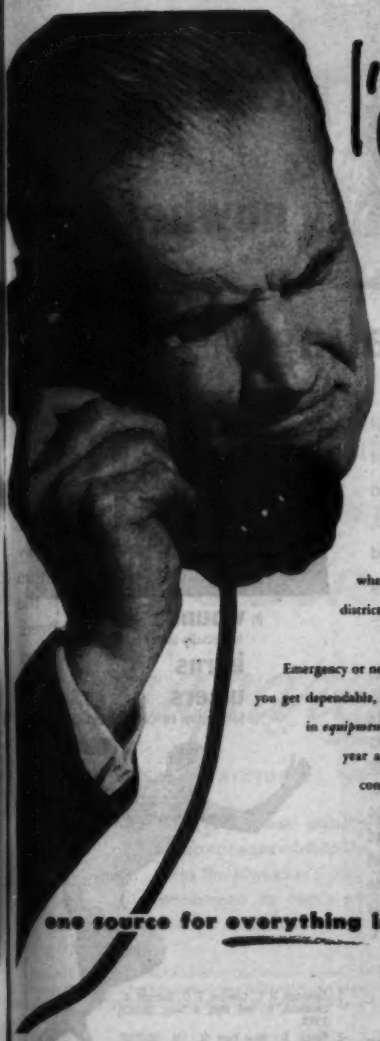

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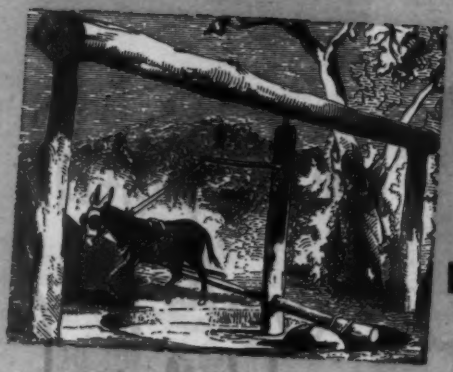

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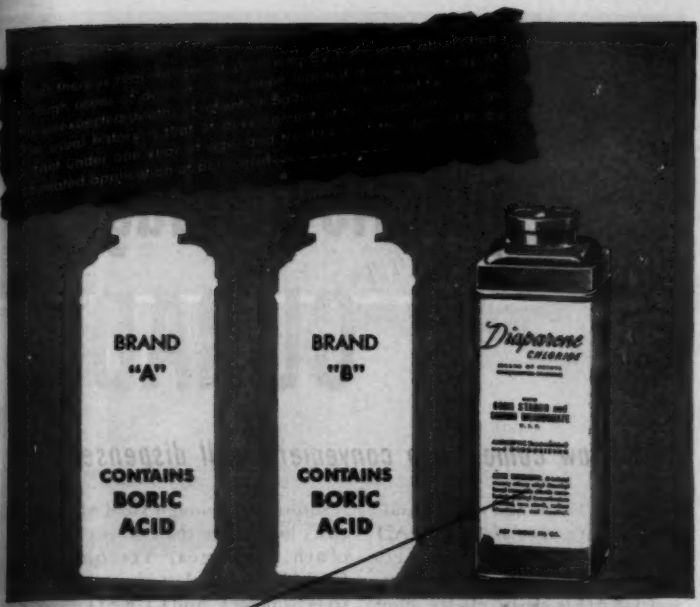
1. Behrman, H. T., Combes, F. C., Bakroff, A., Levitican, R.: Ind. Med. & Surg. 18:512, 1949.
2. Turell, R.: New York St. J.M. 50:2282, 1950.
3. Heimer, C. B., Gruyrel, H. G., and Kramer B.: Archives Pediat. 68:582, 1951.



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1. Eder, R. S. "Notes from The Office of the Chief Medical Examiner," Baltimore, Md., April, 1951.
2. Bauer, E. A., et al.: "The Treatment of Ammonia Dermatitis with Diaparene," J. Ped. 34:1-49, Jan., 1949.
3. Haddam, M. E., et al.: "Ammonia Dermatitis. Treatment with Diaparene Chloride Ointment," J. Ped. 37:5-762, Nov., 1950.

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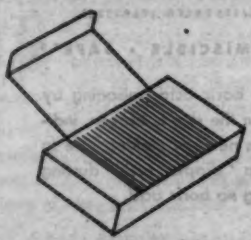

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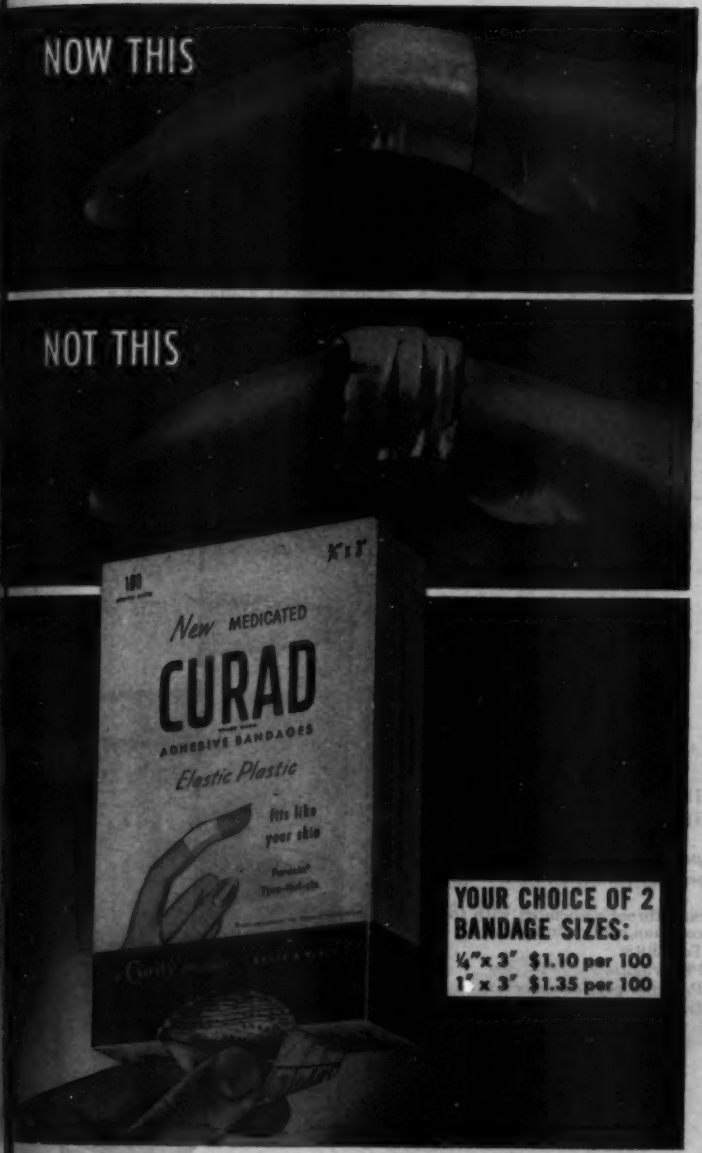
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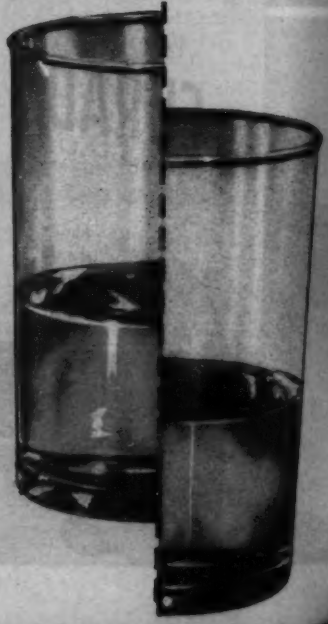

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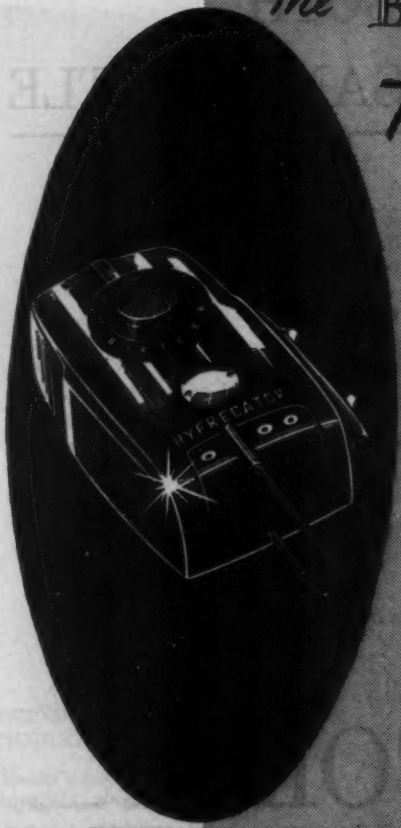

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Dosage: 2 to 4 tablets 3 or 4 times daily (after meals and before bedtime).

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1. *Boyd, L.J., Lombardi, A.A. and Svigals, C.: New York Med. College Bull., 13:91, 1950.*
2. *Meyer, K. and Ragan, C.: Med. Concepts of Card. Disp., 17:2, 1948.*
3. *Quick, A.J.: J. Biol. Chem., 101:475, 1933.*
4. *Guerra, J.: J. Pharm. Exper. Ther., 87:1943, 1946.*

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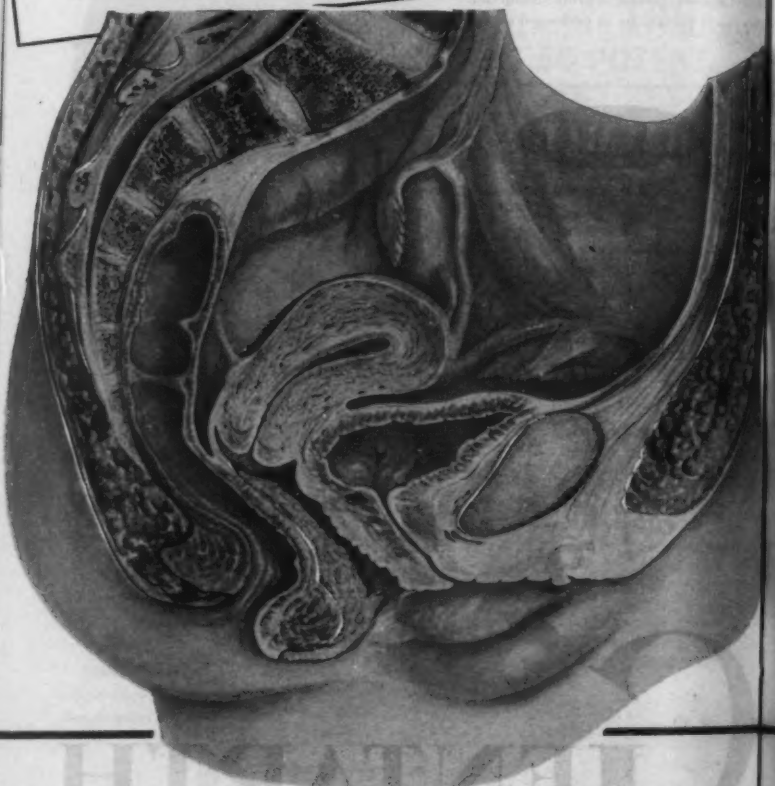

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*Collins, J. H., and Ellington, C. J., Jr.: Vulvovaginitis, New Orleans M. & S. J. 104:220 (Dec.) 1951.

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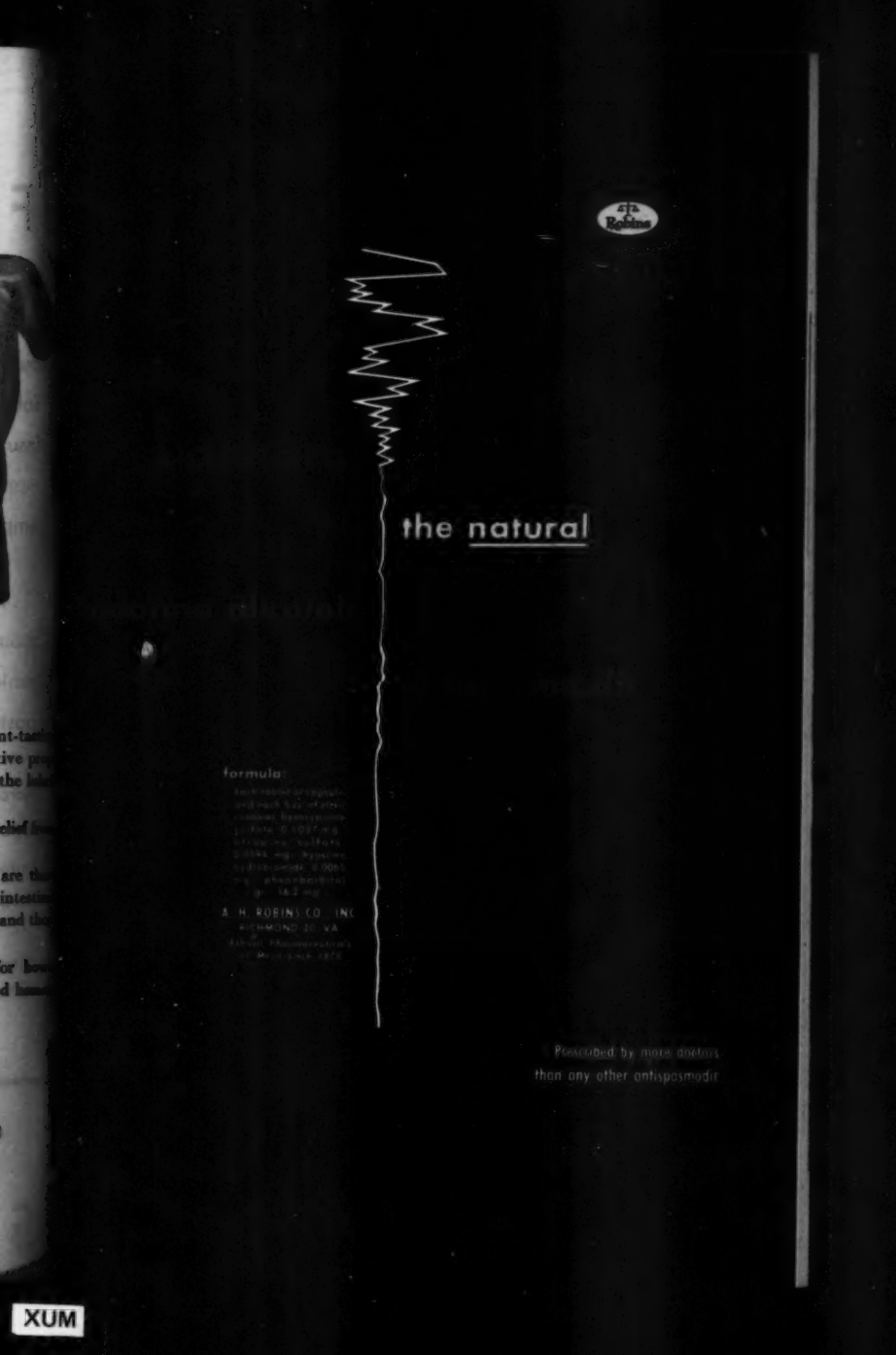
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Editorial

Doctors in Politics

• Two years ago, a good many physicians took their first big plunge into political campaigning. They were utter novices at the game. Yet they helped retire four out of five Congressional sponsors of the national compulsory health insurance bill, as well as whipping its supporters in most other election contests.

Beginners' luck? Hardly. Yet while mobilizing for political action in 1952, our profession would do well to think back on—and this time avoid—certain beginners' mistakes.

Some of these amount to legal lapses. If we distribute anonymous handbills, for example, or if we get our medical societies involved in partisan campaigns, we clearly violate the law.*

A much more pervasive problem, however, relates to the *ethics* of campaigning. Here's the nub of it:

All of us in medicine have political rights; we also have professional responsibilities. Thus, we cannot resort to huckster campaign methods. We cannot associate ourselves with the usual half-truths of campaign propaganda. We cannot campaign at our patients' expense. At least we cannot do any of these things and still retain public respect.

Well, then, what *can* we do? How are we to exercise our political rights and our professional responsibilities—both at the same time?

The answers, as we see them, shape up this way:

1. We can help crystallize the voters' choice. Indiana physicians, among others, have shown us how. In 1950, they wrote every Congressional candidate in the state. They asked a direct question—"Are you for or against compulsory sickness insurance?"—and they put on the pressure to have it answered. Then they published the replies in a pocket-size booklet and circulated it widely. On this prime health issue, at least, Indiana voters were assured a clear-cut choice.

2. We can see that voters exercise their choice. This means sponsoring get-out-the-vote campaigns, complete with block captains, volunteer canvassers, and poll watchers. In Ohio and Michigan, during the last election, these tactics produced eye-opening results. More than 90 per cent of some occupational groups (including medical men and their families) were induced to vote.

3. We can campaign for specific

*See 'Are You Campaigning Legally?' page 30, this issue.

candidates—but only on our own time. This generally rules out electioneering in the hospital or medical office, which is apt to be a risky business. Patients who already share the doctor's sentiments might not mind it; but what about the others?

They could easily resent the injection of politics into a consultation they're paying for. They *did* resent it, two years ago; and in a few such instances medicine won the elections but came perilously close to losing public goodwill.

The impeccable touch is much easier to maintain in after-hours campaigning. Leaflets, posters, paid ads, and radio talks can all be kept factual and dignified. Even campaign letters to patients can be in good taste, as California and Connecticut doctors have proved. (The big booby-trap to avoid: asking for votes "as a favor to your doctor" instead of on the merits of the case.)

Good government means a lot to our profession, and this is the year to go after it with all the energy we've got. But it won't *be* good government unless we achieve it by campaigning on the highest plane.

—H. SHERIDAN BAKETEL, M.D.

What's Money, Anyway!

● He was a stocky man with a fine physique; and he was apologetic for having troubled me on a Sunday. "But I've just got to have an examination," he said.

"Always glad to help anyone in pain," I replied.

"Well, that's the funny part, Doctor. I have no pain." His smile was friendly, yet there was a strange uneasiness in his eyes.

"I'm sorry," I said hastily. "Only emergencies on Sunday. I'll be happy to see you tomorrow."

"Oh, no," he pleaded. "I must have an examination now. I'll pay you well. It's very important."

I was baffled, and my curiosity was piqued. But an hour-long physical proved only what I had suspected: He was fit as a fiddle.

My visitor was elated by the verdict. "Absolutely the best physical I've ever had," he said. "What do I owe you, Doctor?"

"Five dollars," I answered.

"Very good, very good," he said airily, and made out a check.

After the door closed behind him, I glanced at the check. It read: "Five million dollars."

He had diagnosed his case *for* me.

—THEO BOLD, M.D.

Fee Splitting:

Why Is It Unethical?

Does it 'reduce surgery to the level of a confidence game'?

• Fee splitting is unethical. By whatever casuistry some physicians may justify the practice to themselves or to one another, they cannot possibly argue their way around Chapter III, Article VI, Section 5 of the A.M.A. Principles of Medical Ethics:

"When a patient is referred by one physician to another for consultation or for treatment," this section says, *"whether the physician in charge accompanies the patient or not, the giving or receiving of a commission by whatever term it may be called or under any guise or pretext whatsoever is unethical."*

In view of the explicit nature of this dictum, it may seem astonishing that so many doctors ignore it—doctors who wouldn't dream, say, of unethically advertising their services, or of stealing a patient from a colleague, or of making a profit on a secret remedy. One might easily conclude, therefore, that the degree of compliance with an ethical principle varies directly with the chance of getting caught; and that it varies inversely with the amount of money to be made out of violating it.

Fee splitting is generally carried on in secret and is enormously profitable. It differs sharply from most other ethical lapses, which are apparent, if not obtrusive, and are likely to bring the transgressor little but trouble.

It's sometimes claimed that an ethical principle is only as binding as economic circumstance permits it to be. This is partly true; yet many physicians doubtless engage in such practices as combined billing without realizing that they're considered unethical.

Others—possibly a larger group—are aware that their conduct is unethical as defined in the principles, but have convinced themselves that because nobody is getting hurt,

---

By Robert M. Cunningham Jr.

**This is the second of a series on an explosive subject that has too long been kept under wraps. The next article in the series will discuss some of the programs that have been undertaken to combat fee splitting.*

'Don't Fence Me In!'

ere is nothing really wrong with it. In judging the behavior of both ese groups, one should remember t medical ethics, like Christian hics, constitutes a system of moral inciples that may properly be re-arded as *goals* rather than *rules* of nduct. This is plain from the first inciple of medical ethics, which serts that the physician should be pright . . . pure in character . . . ligent and conscientious . . . mod-t, sober, patient, prompt . . . pious." The number of physicians who il to meet this rigid standard can robably be compared with the mber of human beings who fail to e up to the Sermon on the Mount. the same way, the number of doc-s who split fees is probably no ater in proportion to the medical pulation than the proportion of ople generally who lie about their s or cheat on income taxes.

'It's Immoral'

Any such complacent view of fee tting and related ethical trans-sions, however, infuriates med-l moralists. Dr. Paul R. Hawley the American College of Surgeons its with considerable force that doctor's responsibilities toward iety impose on him higher moral ndards than prevail in other ups. Some of Dr. Hawley's hicest invective—and his supply is ndant—is saved for fee splitters. "Why is fee splitting immoral?" said, not long ago. "Fee splitting moral because the interest of the patient is sacrificed to the greed of the doctors. In fee splitting, patients are referred usually not to the best surgeon, not to the best consultant, but to the one who offers most to the referring physician."

Warming to his subject, Dr. Hawley continued: "Fee splitting is, therefore, the sale of the patient's pathology to the highest bidder. It is larceny, since the doctor does not own the patient's pathology and is selling something which is not his own. It is embezzlement, because the doctor has converted for his own use and his own gain something which the patient has placed in his trust. Fee splitting reduces surgery to the level of a confidence game, and the fee splitter to the level of a race track tout."

Whether they agree with this strong judgment or not, some 17,000 surgeons in practice today have taken the fellowship pledge of the American College of Surgeons to abjure fee splitting in all its variations.

"I pledge myself to shun . . . dishonest money seeking and commercialism as disgraceful to our profession," the pledge says in part; "to refuse all secret money trades with consultants and practitioners; to teach the patient his financial duty to the physician and to urge the practitioner to obtain his remuneration from the patient openly; to make my fees commensurate with the service rendered and with the patient's rights; and to avoid dis-

crediting my associates by taking unwarranted compensation."

Some doctors argue that there should be an ethical distinction between out-and-out fee splitting, or commissions for referral, and combined billing by two or more physicians rendering service in the same case.

"I can't see why it is not ethical for any two doctors working on a common problem to send a bill together," Dr. Walter C. Bornemeier of Chicago wrote in a recent issue of the Chicago Medical Society Bulletin. Referring to a phrase that's employed often in moralistic discourses on fee splitting, Dr. Bornemeier went on:

"I wonder what is meant by 'traffic in human life' and I sincerely wonder why this phrase is used and reused, yet no one ever takes the trouble to define and clarify what is and what is not ethical."

Actually, the ethical status of the combined bill is confused because various authorities have given it *too much*, rather than *too little*, attention. Like a patient with obscure symptoms who shows pique because the doctor can't make a clear-cut diagnosis, Dr. Bornemeier is seeking a simple answer to a complicated ethical problem.

There isn't any simple answer. The Professional Relations Committee of the A.C.S. (known as the Cole Committee, for its chairman, Warren H. Cole of Chicago) says: "The combined bill (itemized or not itemized) sent by a physician to a patient is disapproved because either may be a subterfuge for fee-splitting."

While this leaves little doubt where the college stands on combined bills, it still doesn't satisfy Dr. Bornemeier and others. What they want to know is whether or not such bills are considered violations of medical ethics. The A.M.A. principles leave some doubt on this point.

"An ethical physician," says Chapter I, Section 6, " . . . should receive his remuneration for professional services rendered only in the amount of his fee specifically announced to his patient at the time the service is rendered or in the form of a subsequent statement, and he should not accept additional compensation secretly or openly, directly or indirectly, from any other source."

While unquestionably intended to eliminate the kind of combined billing that *is* a screen for fee splitting, this principle does not make it clear that itemized combined bills are also outlawed. Asked for an opinion on this point, several A.M.A. officers replied recently that they think the Judicial Council does consider joint billing unethical—even when the amount each doctor gets is clearly itemized on the joint bill.

Some medical leaders hold that an ethical question is raised even when two doctors on a case render separate bills on their own billheads

[*Continued on page 197*]

'When Doctors Are Patients'

A review of an engrossing book of true stories, all written by physicians

● Here's a profoundly rewarding book* for any physician. It consists of thirty-three case histories unlike any you're likely to have read. Each has been written by a doctor—usually an outstanding man in his field—who has suffered some serious, chronic, or disabling disease. And in every case, the doctor tells his own story—not in cold, precise, objective terms, but with the conviction and feeling of a patient who has stumbled on disaster and turns to his doctor for aid and comfort.

There is warmth in the book, and there is also a kind of cool, heartbreaking self-knowledge. Leaf through the pages, and meet some of your colleagues . . .

Here, for instance, is one of the editors, the late Max Pinner, who was chief of the division of pulmonary diseases at Montefiore Hospital, New York: "It happened ten years ago, in the middle of the night, while I was traveling in a Pullman berth . . . a sudden, sharp pain in my chest—retrosternal, radiating down along the left arm into the fingertips: angina. It was typical enough; sharp and brief. Recognition was instantaneous and beyond doubt . . . This was a new factor in my life that would never leave me, which would enslave me . . . "

Here is Harold Rifkin, an internist who teaches in the New York Medical College. He was stricken in a wartime jungle hospital: "I felt the most excruciating pains in the bones . . . as though the tibia, femur, and humerus were slowly being hammered upon . . . I felt that the bones . . . were being grasped by a circus strong man [in an attempt] to break these into small fragments." He had dengue—"breakbone"—fever.

Here is Lucie Adelsberger, who survived both typhus and the infamous Auschwitz concentration camp: "I had lain in a dark corner, surrounded by the sick and dying . . . One of my fellow sufferers . . . had a terrible encephalitis; [another] had . . . typhoid fever. Particularly painful was the terrible thirst. The water was infected . . . I had to use all my self-control not to drink [it]. That was the worst." [*Turn page*]

*Edited by Drs. Max Pinner and Benjamin F. Miller. W. W. Norton & Co., New York. 328 pages. $3.95.

By Ross C. McCluskey

Rifkin
Dengue fever

Adelsberger
Typhus

Gottlieb
Coronary occlusion

Goldsmi
Multiple sc

Here is the late Julius Gottlieb, a Lewiston, Me., pathologist, who, in five years, had these diagnosed illnesses: duodenal polypi (later disproven); acute left coronary occlusion with myocardial infarction; gastric ulcer (later refuted); acute streptococcic cellulitis of the ear; extensive myocardial infarction; acute cholecystitis; multiple pulmonary infarcts, right mid-lobe; bronchopneumonia; cerebrovascular spasm.

Here is R. H. K., a doctor who fell victim to "God's medicine"—narcotics. And Roy Washington (a pseudonym), whose medicine was alcohol. He started by taking a few drinks between calls, and wound up trying to make a few calls between drinks. Ahead of him lay degradation and, later, rehabilitation.

Here is Walter Erwin (a pseudonym), whose practice unaccountably drove him three times into a manic-depressive psychosis. His is perhaps the most terrible story of all, for it ends with the turning of a key in his office door—forever.

Here, too, are a score of other physicians and their afflictions, some common, some obscure. "I used to be one of those fellows—there is one in every hospital—who could always get into veins when no one else could. Then there was a big arm with easy veins. I missed."

Miller
Editor

Grotjahn
Kidney stone

Stevenson
Bronchiectasis

Low
Poliomyelitis

Wertham
Phlebitis

It was thus that multiple sclerosis hit Norman Goldsmith, a dermatologist of Lancaster, Pa. His is a moving story, yet no more so than that of Martin Grotjahn, a teaching psychoanalyst, who had only a small kidney stone but went almost frantic when one specialist after another gave him little more than a negligent brush-off.

All these stories make fascinating reading. But they add up to much more than just that. Each of the author-physicians gained not only a new understanding of disease but also a new understanding of the patient's point of view. If some of that acquired wisdom rubs off on the book's readers, they'll be better doctors.

Oddly enough, "When Doctors Are Patients" is not gloomy reading. Nearly every man returned to his practice with renewed spiritual strength. Not all of them would say so in just those words, but the fact is implicit in their writing. And, as an inevitable result of their experiences, most of them became vitally interested in psychosomatic medicine.

A doctor who has been desperately ill or disabled can truly appreciate the profound emotional upset, the loneliness, the panic that often grip a sensitive patient. Having

passed along the shadowy road himself, such a doctor is likely to be infinitely better equipped to guide others. For one thing, he has experienced that illogical sense of failure—of guilt, even—that may haunt the patient during the first grim days.

Why should a patient feel guilty because he's ill? It's a totally illogical emotion, observes Ian Stevenson, assistant professor of medicine and psychiatry at Louisiana State Medical School. It's also dangerous, since it impels the sufferer to conceal his symptoms as though they were something indecent.

Stevenson recognized the guilt complex in himself during a siege of respiratory trouble. "The strong have a pervasive contempt for the weak," he says, "but the humiliation felt by the sensitive sick man does not arise alone from the malicious gossip of idle minds . . . Perhaps it comes somewhat from fear that the healthy will hurry by and leave one a straggler on the economic highway . . . Feeling himself responsible for his physical illness, he seeks to hide it as he would his moral vices . . . Physicians do not adequately appreciate this reticence . . . yet it certainly accounts for much of the delay in consulting a doctor."

This view is also stressed by Dr. Quintus West (a pseudonym), who had a long bout with tuberculosis. When he got the first diagnosis, Dr. West wrote his fiancee "a rather overdramatic letter offering to break off our engagement." The letter was "magnanimous on the surface [but] shockingly selfish and, I now realize, subtly brutal between the lines. My letters to my family in another city . . . had a sort of unrealistic quality. My family knew of my illness, but I wrote mostly of trivia and made almost no mention of the most important fact in my life—not, I am sure, out of a decent desire to spare *them* but out of an urgent need to spare myself contact with a painful truth."

One of the most impressive discoveries these doctor-patients made was the great complexity and subtlety of the relationship between a sick person and his physician. It isn't enough, Max Pinner points out, for a doctor simply to treat a patient's illness. The patient wants his doctor to assume full responsibility; he wants to be led like a child.

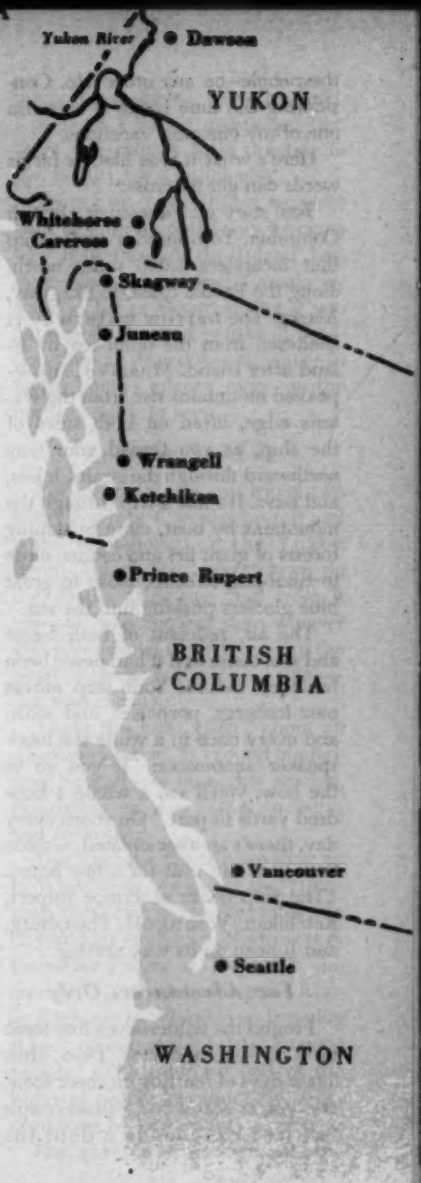
For this reason, it's important for the doctor to understand the patient's way of life as well as his ailment. Says the late Dr. Pinner: "He should not only order the necessary limitations and don'ts . . . he should show his patient the possibilities for enjoyable and fertile living within new limitations."

Are there such possibilities when the "limitations" are really cruel ones? Here are the serene words of Henry Sigerist, the medical historian: "I have three incurable chronic diseases, but I am still able to work with great pleasure from nine o'clock

[*Continued on page* 147]

I Took an Alaskan Vacation

Ever thought about cruising through the land of the glaciers? Let this physician tell you what it's like



Thirty-six years ago, fresh from internship, I spent six months as a ship's surgeon and twice made the thousand-mile trip up the Amazon. Since then, whenever I've had the time and the money, I've taken delight in traveling.

I thought I'd seen everything worth looking at in Europe and the Americas. But it turned out I was wrong.

My pruritus pedis gets especially acute along about July, when the asphalt outside my New York office becomes putty underfoot. Last summer I got relief by taking a ten-day Inside Passage cruise to Alaska and part of the Yukon. It's hard to talk about it without sounding like a travel blurb, but I have never enjoyed myself more—or the sights or

By Maurice M. Pomeranz, M.D.

the people—on any other trip. Considering the time spent, it was also one of my cheapest vacations.

Here's what it was like, as far as words can get it across:

You start at Vancouver, British Columbia. You board a cruise ship that meanders 1,000 miles north, along the Pacific coast, to Skagway, Alaska. The narrow waterway is sheltered from the open sea by island after island. Massive, snow-peaked mountains rise from the water's edge, often on both sides of the ship, as you thread your way northward through the straits, inlets, and bays. It's like a trip through the mountains by boat, close to sloping forests of giant firs and cedars, close to tumbling streams, close to great blue glaciers pushing into the sea.

The air, redolent of both forest and sea, tastes as if it had never been breathed before. Your ship moves past icebergs, porpoises, and seals; and every once in a while the loudspeaker announces: "If you go to the bow, you'll see a whale a hundred yards to port." On shore every day, there's another isolated, seaside town you can visit for a few hours. (The ship docks at Prince Rupert, Ketchikan, Wrangell, Petersburg, and Juneau on its way north.)

For Adventurers Only

I found the wilderness a fine tonic for a city-weary doctor. Then, after a few days of feasting on sheer scenery, you're ready for a landscape that men have made a dent in: where they've done something dramatic, foolish, or romantic. This you find at Skagway, the north end of the Inland Passage, where your ship finally docks.

Here, during the Klondike gold rush, wild-eyed prospectors left their boats to start the eighty-two-mile trek northward, over White Pass, to the headwaters of the Yukon River. Skagway today is a shrunken relic (pop. 600) of the boom town that once had a dozen dance halls, sixty saloons, and 1,200 prospectors' tents on the beach. Even so, you can almost feel yourself stepping back sixty years into the gold-rush atmosphere.

Your ship lays over at Skagway for two days. This gives you time to travel part way along the "Trail of '98" toward the Klondike. You don't have to do it on foot or by raft, as the prospectors did; you can go by steamer and by narrow-gauge railway.

Better Than Europe

Nothing I've ever seen is more spectacular than this rail trip over White Pass (and I'm not forgetting Norway, the Swiss Alps, or the Italian Dolomites). Up through gorges, across canyons, along the lip of a mountain, your train winds toward a vast boulder-strewn plateau. Then it dips down into blue-green lake country, and you're in Yukon Territory.

The train goes as far as Whitehorse; but two-thirds of the way

there, you can get off at Carcross (for Caribou Crossing), an Indian village on Lake Bennett. My wife and I boarded an old stern-paddler steamboat there for an overnight trip down the string of mountain-cradled lakes known as West Taku Arm. It's the kind of boat I've always wanted to take down the Mississippi, and never have.

For a hundred miles or so, on this steamboat excursion, there isn't a glimpse of a human dwelling. Then, suddenly, at the far end of everything, there's an old homestead—and a romantic story.

Dream House

This is Ben-My-Chree (Manx for Girl of My Dreams), built by Otto Partridge and his wife. They were a young, cultured couple from the Isle of Man, in the Irish Sea, who footed it over the trail with the other prospectors of '98. They discovered and ran their own gold mine, back here in the glacier-draped mountains.

Then, one day, an avalanche buried their mine. But gold or no gold, they stayed on together in their snug cabin for forty years. They were isolated all winter, but welcomed visitors in summer and worked on their magnificent garden.

Their garden still stands, and it's really something to see. Gigantic dahlias, sweetpeas, marigolds, nasturtiums, and forty other flowers bloom unseasonably together, forced out by the long daylight of the short northern summer. My wife might have stayed here for good, I think, if I hadn't mentioned that there was mighty little practice in the vicinity for a radiologist.

From Ben-My-Chree, we went back to Vancouver the way we came—by boat through the Inland Passage. Then we crossed Canada by train, as far as Montreal. But if you have more than two weeks of vacation time at your disposal, you're in luck: There's plenty more of the north country to see.

Vacation Specials

For example, you can travel two hours north of Carcross by rail and reach Whitehorse, on the Yukon River. This is the biggest town on the Alaska Highway; and from it you can take another stern-wheeler 460 miles down the Yukon, into the heart of the Klondike (it's a twelve-day round trip).

That's the best thing about an Alaskan vacation, as I found in planning ours. It can be highly flexible, depending on your time, money, and fortitude.

You can take the trip we took up to Whitehorse, including the Yukon tour, then fly back to the states in a day by Pan-American, Northwest or Canadian Pacific airlines. Or you can drive your own car up the Alaska Highway to Whitehorse, bringing it back on one of the Inland Passage vessels. (The southern end of the highway proper lies about 300 miles northwest of Edmonton, Alberta.)

For our part, we went on the

Canadian Pacific liner, Princess Kathleen. But there are other cruise ships—for example, those of Canadian National or of the Alaska Steamship Company from Seattle The latter service goes much farther up the Alaska coast, to Seward.

Costs? We took luxury cabins and the tab was about $300 each for the ten-day cruise itself. (You can make the same trip for as low as $185 on this ship, $150 on some others.) Beyond Skagway, the side trips cost extra. For the twelve-day Yukon River tour, for example, the cost is $150 per person.

Traveler's Tips

Every returned traveler usually has a rich assortment of memories and suggestions. Here are a few of mine:

The Ship. You can leave your Dramamine at home. The sailing is so smooth that even my wife, who generally gets seasick the minute she walks up the gangplank, never had an uneasy qualm. There's plenty to do on board ship, too, and the crew is unobtrusively courteous.

Food and Drink. Aboard ship, the meals are excellent; they compare favorably with those on the best transatlantic liners. And while Alaska is no gourmet's paradise, the food ashore is simple yet interesting, with plenty of fresh fish. My most memorable meal was a moose-meat steak dinner between Skagway and Carcross (it tasted like tough but toothsome beef).

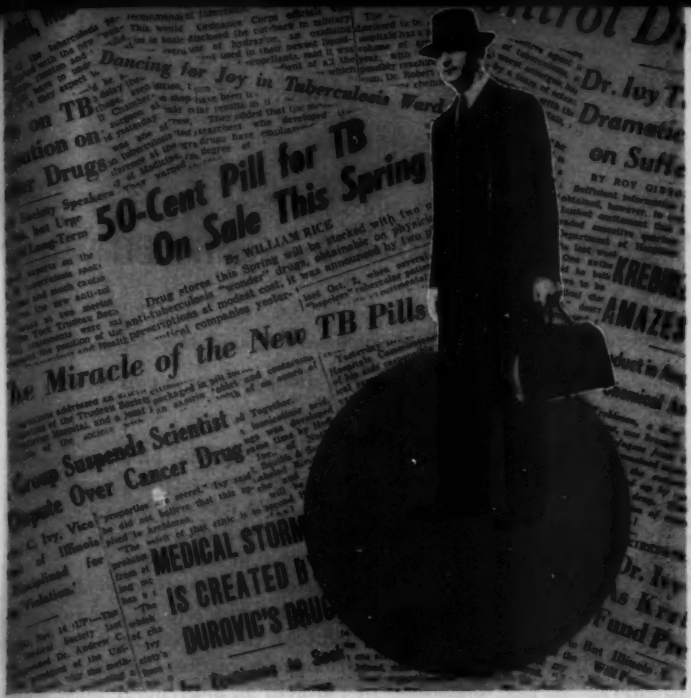
Canadian ships don't serve liquor within the three-mile limit. Which means no drinks till you get to Alaskan waters—unless you're foresighted. In Alaskan towns, however, lively bars line the streets and all serve good drinks. At Juneau, you can get highballs with 10,000-year-old ice in them (hacked off the near-by Mendenhall Glacier). It's clear and bluish and it melts more slowly than new ice.

Fishing. All the way, Alaska is a fisherman's country. In the lakes and streams around Whitehorse, for example, grayling, whitefish, trout, and northern pike grow up to forty pounds. I fished for a day near Vancouver before boarding the ship, then dropped the sport for sightseeing. At Juneau, I found it more fun to watch the annual run of salmon up rivers and falls than to catch them.

Photography. One fellow passenger, I'll swear, didn't see Alaska at all except through his camera's viewfinder. I understood his fanaticism, but deplored his lack of sense in settling for secondhand experience. I took a few shots myself and found the weird, quick-changing light a real challenge in color photography. Bring color film with you, though; it's hard to buy up there.

Weather and Clothes. It's colder than the travel folders say. In the sun, you can go without a shirt; but around the corner in the shade, you need a coat. In Glacier Bay (near

[*Continued on page* 205]



TB/Cancer Drug Ballyhoo Puts Doctors on Spot

• During the past several months, laymen have been confused, and medical men embarrassed, by two ill-planned offensives in the war against disease. The effects of premature and sensational publicity have been far-reaching, the implications worth analysis. Here, then, is a portfolio of two full-length articles that clarify—and interpret—what really happened in the case of (1) Krebiozen, the secret anti-cancer drug sponsored by Dr. Andrew C. Ivy, and (2) isonicotinic acid hydrazide, the new TB drug.

'Now There's Dancing in the TB Wards'

Jay was unconfined, said the newspapers. But there was disappointment as well

● On Feb. 21 last, the medical profession had the privilege of being let in on the secret of a new and important therapeutic agent at exactly the same moment as the general public. Most doctors were not appreciative.

The drug, of course, was isonicotinic acid hydrazide, developed simultaneously by Squibb and Hoffmann-La Roche. Front-page newspaper disclosure of test results of these companies' products set off the greatest hullabaloo in the field of tuberculosis since Robert Koch developed tuberculin in 1890.

Within two weeks of the announcement, the original couple of hundred experimental patients in four hospitals were reported to have increased to 10,000 in 300 hospitals. Orders for the drug poured in from all over the world. Previously docile patients refused necessary surgery, sulked over their streptomycin, and rebelled in a dozen other ways against established treatment.

Where long lines of men and [*Continued on* 82]

By William A. DeWitt

**Mr. DeWitt is a free-lance writer for magazines, as well as the author of several books. In preparing this article, he interviewed dozens of medical men—many of them directly involved in the clinical investigation of isonicotinic acid hydrazide.*

'Today Science Found a Cancer Cure'

Thus the U.S. press introduced Krebiozen to the world—and Dr. Ivy to trouble

● Last winter, Dr. Andrew C. Ivy, one of our best-known leaders in medical science, took a two-month leave of absence as vice president of the University of Illinois in charge of its Chicago professional schools. His purpose, I'm told, was to prepare and publish a report of perhaps 500 cases of human cancer treated with Krebiozen.

If my information is correct, Dr. Ivy will not claim that Krebiozen is a cure for cancer. He will, however, strike a positive note, tending to bear out his original, hopeful claim for this product of the horse.

Krebiozen, to be explicit, is a serum purportedly obtained by somehow stimulating the horse's reticulo-endothelial system. The drug's manufacturer, Dr. Stevan Durovic, a Yugoslav who entered the U.S. from South America, called the stuff Krebiozen, because he looked upon it as a biological-growth regulator.

Krebiozen has, at any rate, created one of the less pleasant episodes in man's long history of search for a cure to cancer and of claims [*Continued on* 83]

By Greer Williams

**Mr. Williams has written many pieces on scientific and medical subjects for The Saturday Evening Post and other magazines. This article is being published simultaneously in the May issues of* MEDICAL ECONOMICS *and The Modern Hospital.*

'Now There's Dancing in the TB Wards' *(Cont.)*

women used to wait their turn to be examined in mobile X-ray units, potential victims now stayed home. And why not? Inexpensive pills would soon be available to cure the disease; even the conservative New York Times had said so.

As a matter of fact, the New York Times *had* said so, in effect. But with qualifications. Other papers qualified the story, too; and prominent chest specialists warned against overconfidence. But the words of caution got mostly backpage space. The headlines spelled an unqualified story of hope.

The script is all too familiar. Hasty claims on limited evidence are nothing new; neither are the melancholy results. No matter how isonicotinic acid hydrazide finally measures up as a weapon against tuberculosis, thousands of patients are likely to be disappointed. These will probably still have to face surgery, hospitalization, and the use of more expensive drugs. And as the ground for hope sinks from under them, there'll be an added psychological burden. This is perhaps the worst thing about such situations: the widely publicized build-up, followed by the shattering let-down.

How do such things happen? Is there any way to prevent premature, disorderly, and sensational announcement of important new

[*Continued on page* 175]

Earl Wilson

Marcus D. Kogel

A columnist's rumor leads to a commissioner's headache

'Today Science Found a Cancer Cure' *(Cont.)*

that he has found a cure. It is that long and frustrating history that has conditioned medical scientists and writers to doubt any new story of a cancer treatment.

After Dr. Ivy, in rather unorthodox manner, stepped forth a year ago as the sponsor of Krebiozen research, both his medical friends and the skeptics were puzzled. Here, after all, was no Johnny-come-lately or catchpenny patent-medicine man, but a distinguished physiologist, long associated with such dignified institutions as the National Research Council and the National Cancer Institute. Here, if ever, was a man who should know better.

Why, therefore, did Ivy do it?

He has pointed out, correctly, that his original claim for Krebiozen was moderate: "It is my opinion . . . that Krebiozen merits a very thorough clinical study and evaluation . . . It should be made clear that Krebiozen is not to be viewed as the final goal in the chemotherapy of cancer . . . It should also be made clear that Krebiozen is not now available for distribution to all patients."

There were few other signs of moderation, however, in the commotion surrounding the unveiling of Krebiozen in the French Room of Chicago's Drake Hotel on March 26, 1951. The meeting was called by

[*Continued on page* 151]

Andrew C. Ivy

Stevan Durovic

Should a scientist sponsor a stranger's mystery drug?

Endowment Insurance: A Good Buy?

How your premium dollar pays off endowmentwise —and otherwise

● One afternoon last month, a surgeon dropped into my office for some advice. Our conversation went something like this:

"I've been in practice eleven years," he began, "and I'm living pretty comfortably. I've got $20,000 worth of life insurance, but outside of that and a few hundred dollars in the bank, I've made no provision for the future. Never thought much about it, in fact, until I turned 40 a couple of weeks ago. Then I decided it was time to look ahead a bit.

"As a result, I plan to buy more life insurance. I also want to set up some systematic way of saving money. I've heard about endowment insurance, and it seems to fill both needs.

"What I have in mind," he said, "is a $10,000 twenty-year policy. This, I understand, would pay my wife $10,000 if I died within the next twenty years. If I lived until 60, I'd collect the $10,000—a tidy nest egg that I could use for travel or as part of a retirement program. The point is, I'd be saving money and protecting my family at the same time."

I smiled. "Sounds like you're practically sold. What's the hitch?"

"Well, it's pretty expensive stuff," he said, handing me a sample policy. "As you can see, it would cost me $495 a year. Is that out of line?"

"Not with similar endowment contracts," I replied. "This is typical of the non-participating (no dividend) policy. Those that do pay dividends may cost slightly less in the long run; but you can't be sure since dividends are never guaranteed."

"Then it's really worth the price?"

"That's something you'll have to decide for yourself," I answered. "The best I can do is give you some facts and figures. But, first, here's something to remember: An endowment policy has at least one very real virtue; it *forces* you to save money."

He laughed. "That *is* a virtue."

"Yes. If you tend to let money slip through your fingers, endowment insurance is one means of making you hold on to some of it. It compels you to save systemati-

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*By W. Clifford Klenk**

**Mr. Klenk is a New York City insurance consultant.*

cally. But now let me show you how you'd make out if you invested an equal sum in another way.

"First, let's match the life insurance protection offered by the endowment policy. Level-premium, non-reducing term insurance would furnish you the same protection ($10,000) over the same period (twenty years) at a cost of $152 a year. That's $343 less than the annual endowment premium.

"Now suppose you set aside that extra $343 every year. You could put it into stocks, bonds, savings accounts, or a combination of these. Your return, of course, would depend on how you invested it. But let's be conservative and say you got 2½ per cent interest.

"At that rate, and without counting probable appreciation, you'd have $8,980 at the end of twenty years, or about $1,000 less than the endowment policy offers.

"Now, let's suppose you died *within* twenty years. An endowment would pay your wife $10,000. But from a combination of term insurance and savings, she'd get $10,000 in insurance *plus* the savings. In five years, this would total $11,848; in ten years, $13,938; in fifteen years, $16,303.

"Thus, if you died within the twenty-year period, your family would be much better off with the term insurance-plus-savings combination.

"There's another thing to consider, too. While the strongest argument for endowment insurance is that it forces you to save, some people find this an equally strong argument against such a policy.

"Why? Well, suppose that some time during the twenty years ahead you suffered financial reverses. With the endowment policy, you'd be saddled with a fixed annual obligation of $495.

"Of course, you could cash in your insurance, take a paid-up policy, or borrow on it. But none of these solutions would be very satisfactory. Consider the choices open to you at the end of the tenth year:

¶ "You could cash in your policy for $3,920. That would be about $1,000 *less* than the $4,950 you'd have paid in premiums. And you'd be losing your insurance as well.

¶ "You could settle for a paid-up policy of $5,170. In which case, you'd still have about half your insurance protection. But at the end of the twenty-year period, you'd get only $5,170—a pretty poor return on an investment of $4,950.

¶ "You could borrow on your policy up to $3,920 (its cash value) at 5 per cent interest. That would drop your insurance protection from $10,000 to $6,080 ($10,000 minus $3,920). It would also increase your annual payment to $691 ($495 premium plus the 5 per cent interest on $3,920).

"Under the alternate program, your only fixed obligation would be the $152 annual premium for the term insurance. This policy would

have no cash-in or loan value, but you would by now have $3,938 in non-insurance savings, which you could draw on if necessary.

"And remember, this comparison assumes an interest rate on those savings of only 2½ per cent. With good stocks or shares in a mutual fund, for example, you could probably do much better. You'd also be able then to experience some growth of principal—an all-important consideration with Federal income taxes geared the way they are."

The doctor looked thoughtful. "Would the same reasoning hold true if I were to buy an endowment to provide for my children's college education?" he asked.

"Pretty much so," I answered. "You could apply what I've said to that, too, if you were willing and able to plan ahead."

"What you've told me," he mused, "seems to boil down to this: If I need a whip hand over me to save regularly, an endowment policy will provide it. But if I can set up a systematic savings program on my own, and stick to it, I'll be better off without such a policy."

I nodded. The surgeon had stated the case exactly. There was just one more point to make, so I concluded:

"Even enforced savings are not an exclusive advantage of endowment insurance. Mutual funds, for example, with their initial 'loading' charges and their installment-purchase plans, create the same compulsion to save regularly." END

Good Form In Referra

• "So he goes merrily ahead
operates, with never a peep to
gripes the referring G.P. Or, in
other instance, "Never *did* see
patient again."

The specialist, on the other ha
has his own pet beefs: "He se
me this fellow, mind you, with
information at all about his hist
or treatment to date." Or: "W
didn't he *tell* me what disposi
he wanted made of the case?"

Most such complaints need nev
arise, according to Drs. Joseph
Telford of San Diego and John
Long of Sacramento. Nine out
ten referral difficulties, they belie
stem from poor teamwork. The r
ferrer fails to pass on all the info
mation he should; the consulta
makes insufficient effort to obtain
—and to keep the referrer inform
of *his* findings.

Late in 1950, Drs. Telford a
Long put their heads together
produce a referral form that wou
meet the needs of most specialis
and general practitioners. After
year of testing and revision, th
came up with the blank reproduce

CONSULTATION AND REFERENCE REQUEST

Introducing: James W. Harlman — Date: March 6, 1952
Referring Physician: Leo H. Stone, M.D.
Referred to: A. B. Sanderson, M.D.
Tentative Diagnosis: Probable carcinoma of the sigmoid
Consultation Requested: Diagnosis and recommendation

Case Work-up Pertaining to This Illness

History:

Weakness
Weight loss - 20 lbs.
Progressive anemia
Constipation - 6 months's duration

Past History: Removal of rectal polyp in 1948
Pathologist reports no malignancy

Positive Physical Findings:

Evidence of weight loss
Pallor
Weakness
Sigmoidoscopy negative

Laboratory and X-Ray Findings:

RBC 4,300,000 — PMN 65% — Lymphs 39%
Hgb 8.6 gms. 53% — Stabs 2% — Monos 3%
WBC 4,900 — PMN 1% — Occult blood steal 4 plus
Barium enema with air contrast reveals a large filling defect, the proximal end of the sigmoid, suggestive of a malignancy.

Medications or Treatment to Date, Dates:

None

Financial Recommendations:

Bill patient direct

(Use reverse side for further information)

Requested Disposition of Case

Conclusions and Report sent:
- Return patient as soon as consultation work-up is completed
- Return patient after conclusion of care for this illness
- Assume management for this particular illness
- Assume future management within your field

Explain to patient:
- Diagnosis
- Further treatment
- Refer back for interpretation and treatment

If Surgery is indicated
Referring physician requests to:
- Assist
- Perform surgery
- Give anesthesia
- Consultant proceed without referring physician participation

(AMP) emblem

here (actual size: 8½" x 11").

According to the California Academy of General Practice, the form has won spontaneous acclaim. Says that organization: "While . . . admittedly open for further refinements and improvements, it is a significant step forward towards improving specialist-general practitioner relationships." END

Supreme Court Quashes Kickback Case

And, as a result, the Revenue Bureau's drive to disallow split-fee deductions by M.D.'s will probably be restricted to those states that have laws against fee splitting

● Thomas and Helen Lilly had an optical business in North Carolina and Virginia. They also had a business arrangement with a good many local M.D.'s. Under it, one-third of the sales price of each pair of eyeglasses the Lillys sold was turned over to the prescribing physician.

This arrangement raised few eyebrows in the cities where the Lillys maintained their offices.* Most patients didn't know about the deal; most doctors accepted it as a fixed feature of the optical business. Between 1942 and 1944, therefore, the Lillys kicked back nearly $200,000 to eyeglass-prescribing physicians and no one thought much about it.

But plenty of people have thought about it since. First the tax experts, then lawyers and lower-court jurists, and now the justices of the U.S. Supreme Court have all pondered the case.

So have a good many physicians —and understandably. "The Lilly case," said one man a few months ago, "is going to result in raised medical ethics and lowered medical incomes."

This prediction is likely to come true, it now appears; but in a limited sense. You can gauge the future influence of the Lilly case by reviewing its recent history, right up to the Supreme Court decision this spring:

The Lillys ran afoul of the Revenue Bureau more than five years ago. At issue was the deductibility of the sums they'd paid to physicians ($65,000 in 1944, comparable amounts in previous years).

On their Federal income tax returns, the Lillys had listed these sums as "ordinary and necessary expenses of carrying on business," thus excluding them from their taxable income. They hadn't kept the money, they reasoned; so why should they pay taxes on it?

But the Revenue people thought otherwise. Such kickbacks "violated public policy," they ruled, and hence were non-deductible. The Lillys were rocked with a $124,-

*Fayetteville, Greensboro, and Wilmington, N.C.; and Richmond, Va.

By R. Cragin Lewis

107.78 bill for tax deficiencies.

This was more than the Lillys could stand. They took their case to the Tax Court—and lost. They moved on to the Circuit Court of Appeals—and lost again. One more step remained for them: an appeal to the U.S. Supreme Court.

Meanwhile, certain Revenue Bureau higher-ups made a move of their own. Their move, oddly enough, was directed against doctors. Emboldened by lower-court approval of the policy against kickbacks, they extended it to medical split fees.

Accordingly, during the summer of 1951, local tax agents were instructed as follows:

All sums paid by one physician to another as a split fee are NON-DEDUCTIBLE *on the tax return of the doctor paying and are* TAXABLE AS INCOME *to the doctor receiving said sums . . .*

This meant, of course, that *both* doctors taking part in any such transaction would be taxed on the amount that changed hands.

That's been the prevailing policy ever since. Some doctors have damned it as "double taxation without representation." Others have praised it as "hitting ethical violators in the pocketbook nerve."

On March 10 of this year, the Supreme Court finally spoke up. Its unanimous decision in the Lilly case: "The question here is whether [kickback] payments were deductible . . . as ordinary and necessary business expenses . . . For the reasons hereafter stated, we hold that they were."

What *were* the Supreme Court's reasons? Mainly, that the Lillys had violated no law—there having been no anti-kickback statute in either North Carolina or Virginia as of 1944.

Justice Harold Burton summed up the court's sentiments thus: "We do not have before us the issue that would be presented by expenditures which themselves violated a federal or state law . . . In such a case, it could be argued that the outlawed expenditures . . . were not 'ordinary and necessary' business expenses."

Note that last part carefully. Disallowance of such deductions wasn't universally wrong, the court implied, but only in this case.

Justice Burton hinted that deductions *could* be disallowed if they "frustrate sharply defined national or state policies proscribing particular types of conduct." But he added: "The policies frustrated must be national or state policies evidenced by some governmental declaration of them. In 1943 and 1944 there were no such declared public policies proscribing the payments which were made . . . to the doctors."

What will this mean to medical men? While the Revenue Bureau hasn't announced its revised policy, the Supreme Court decision clearly stakes it out. Tax experts both in and out of government agree that this is what physicians may expect:

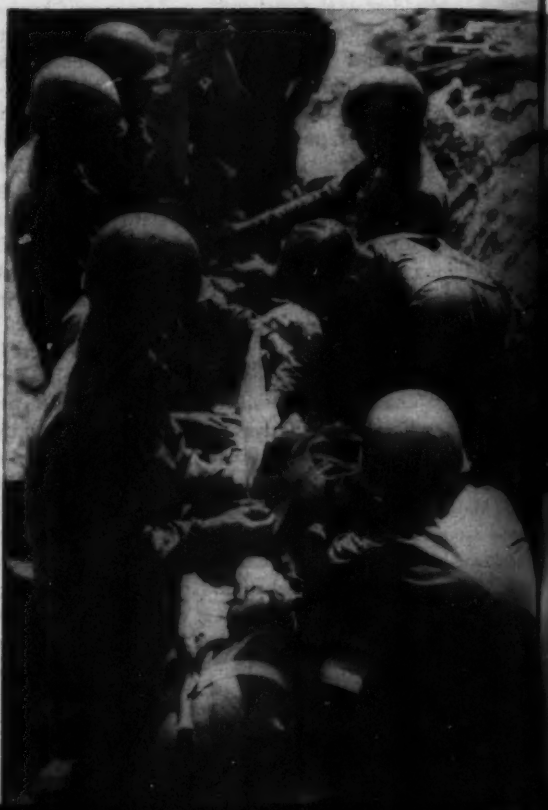
1. *A continued disallowance of*

[*Continued on page* 173]

What We've Learned In Korea

● On the scoreboard for military medicine in Korea, this fact stands out: Of each 1,000 battle-wounded men who reach a front-line aid station during periods of active fighting, only twenty-five die. In World War II, the comparable mortality rate was forty-five per 1,000; in World War I, it was eighty-three.

This means that in a no-quarter war fought in formidable terrain and weather, medical men in Korea have done the best lifesaving job in mili-



tary history—once they've been able to get their hands on the wounded.

How have they done it? What improvements in military medical methods have helped them to achieve this record? New drugs and better medical techniques mean a lot. But Maj. Gen. George E. Armstrong, Surgeon General of the Army, gives major credit to these factors:

1. The high caliber of today's doctors, with their remarkable professional know-how.

2. Development of the sixty-bed mobile Army surgical hospitals. These units, says General Armstrong, "have brought superb surgery up close to the front lines."

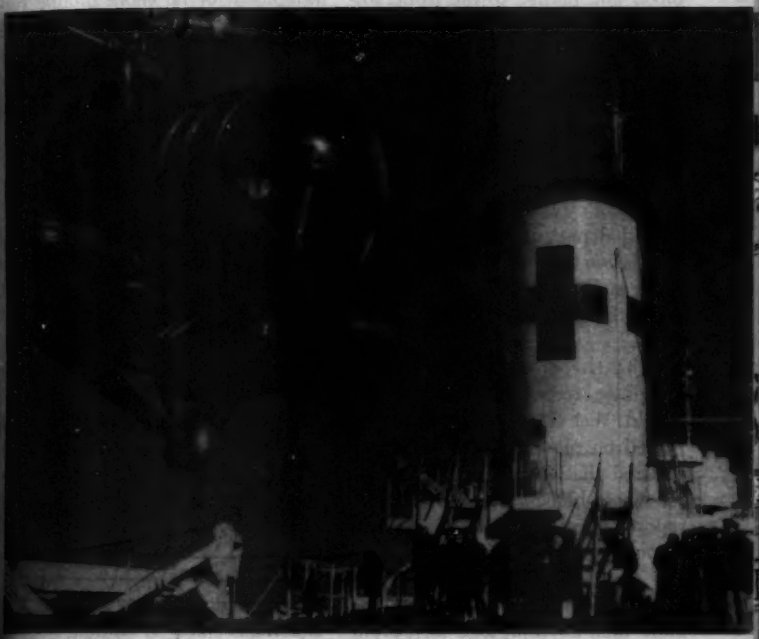
3. Air evacuation, including helicopter rescue, which "cuts hours to days from the time required to get the severely wounded to specialized medical care."

[*Text continued on page* 94]

By John Byrne

With surgery now available much closer to the front [◀], many lifesaving operations can be performed on the spot. Here, a battalion surgeon (the medical officer nearest the firing line) amputates a soldier's leg near Seoul. Other critically wounded men [▲] are placed in litter capsules (one on each side of the helicopter fuselage) for a quick lift to a mobile Army surgical hospital. Such short cuts from battlefield to surgery are largely responsible for the reduced death rate in Korea.

First tested early in the Korean war, the mobile Army surgical hospital (MASH for short) is a multiple-tent unit that's moved as the battlefront shifts. In four hours, it can be set up for major surgery. It is usually moved in two parts to avoid interrupting the hospital's work. One MASH staff includes three administrative officers, sixteen M.D.'s, seventeen nurses, and 131 enlisted men. Here, in a MASH surgical tent, Maj. Jesse F. Brown of Coltewan, Tenn., administers whole blood to a newly arrived casualty.



Direct from a battlefield, a helicopter brings in two casualties to the new landing platform of the hospital ship Consolation. In this latest experiment to speed evacuation of wounded, the ship was anchored half a mile off the Korean coast near the 38th Parallel. Helicopters also fly surgical teams and equipment from ship to near-by battle areas.

Aboard another hospital ship, the convalescents recover enough to stand up and take nourishment. But the soldier at the left still takes a dim view of Navy chow.

4. Ingenuity in speeding whole blood and plasma to the front, following air express deliveries from the U.S.

In helicopters, whole blood can be flown even to aid stations when urgently needed, says General Armstrong. He adds: "I have seen these vehicles fly forward with whole blood to evacuate a critically-wounded patient . . . wait for the transfusion to start, and then fly back to the mobile Army surgical hospital while the patient was being transfused."

Why the emphasis on whole blood? According to Armstrong, "In World War II, reliance was first placed on plasma, but later it was realized that there is no substitute for whole blood . . ." In Korea, he reports, the availability of large amounts of whole blood in the mobile surgical hospitals (plus the use of plasma at the front) "has done more than anything else to prevent or relieve shock—that great killer of the severely wounded."

Thus, to a large extent, the Army's combat medical gains have been a result of closing the time-and-space gap that separates the wounded soldier from definitive surgical care. Surgeons have been moved up closer to the front. Their patients reach them more quickly after being hit.

Navy's Surgical Teams

These tactics have been matched by the Navy, too, in its medical coverage of Marines. A vital Navy innovation in Korea has been the development of far more mobile surgical teams. Explains Rear Admiral Lamont Pugh, Surgeon General of the Navy:

"These teams consist of a surgeon, his assistant, a physician-anesthetist, and ten specially trained hospital corpsmen. We had twenty-five of these teams in the field at the peak of Marine Corps operation in Korea, and I believe they will remain a valuable part of our combat organization. They have great flexibility . . . and can be flown . . . to points of casualty concentration, including casualty-carrying ships."

Formerly, Navy medical officers who went ashore in the first waves of landing forces could administer only temporary treatment to the wounded. For major surgery, patients had to wait until they could be taken to a transport or hospital ship several miles off the beach. But Korea has changed all that.

First proving ground for the Navy's new surgical teams was the 1950 amphibious landing at Inchon. There, four teams went directly to the beaches in landing ships with fully equipped operating rooms. During the early hours of the assault, nearly all critically wounded troops were operated on aboard the beached LST's, including even those men requiring extensive chest and abdominal surgery.

The same Navy teams pack up and go inland with the troops when the beach is cleared. After the In-

chon landing, for example, one team moved on to a battered building on Kimpo airfield. The surgeons were ready to operate again 65 minutes after their trucks rolled onto the airstrip.

Medicine Not Static

Will these advances in medical logistics become standard procedure in the future? Military leaders think so. But they warn that new wars always demand new methods. Helicopters, for example, dramatic as they are when used as flying ambulances, might not work out against an enemy with air power comparable to ours. And as Admiral Pugh points out, military medicine is never static. "We have to devise plans for all sorts of war conditions different from those we've found in Korea."

In the end, however, it's the medical officers' skill that plays the biggest part in saving lives on the battlefield. Which is what Gen. Matthew B. Ridgway, Commander-in-Chief of the Far East Command, was getting at when he praised his Army doctors in Korea recently:

"Our senior medical officers have never spared themselves, but have personally directed evacuation of our wounded under conditions fraught with extreme danger and difficulty."

END

"By the way, Fred, when can I expect something on your bill?"

Before You Sign a Lease

That's the time to follow these tips for avoiding landlords' booby traps

● After a long search for more adequate quarters than his cramped two-room office, a Midwestern G.P. found a vacant four-room suite on the ground floor of a large apartment building. It seemed like an ideal set-up, except that it needed some major repairs. But the owner described at great length the improvements he would make "now that I've got a tenant who'll appreciate them." Catching the landlord's enthusiasm, the G.P. signed a long-term lease.

When a couple of weeks went by without any repairs having been made, he started to worry. A phone call to the landlord confirmed his suspicions. "I understood that *you* were to pay for those repairs," said the landlord. Stuck with his hastily signed lease, the doctor had no choice but to foot the bills—which came to almost $1,000 before the office was fit to practice in.

"Look before you lease" has been shouted at generations of tenants. Yet the average tenant still signs up with only the foggiest notion of what's in the fine print—and without making any attempt to modify objectionable features.

Even the most cautious medical man, of course, stands little chance of getting *exactly* the lease he wants. Most standard forms protect the landlord somewhat more than the tenant. And many doctors feel that trying to bargain with a landlord these days is a waste of time.

Yet physician-tenants are in a far better position to wangle concessions than is sometimes imagined. They usually pay higher rents for their offices than comparable residential quarters command. Moreover, in some areas where postwar apartment construction has been heavy, there's actually a tenant's market in professional suites. Landlords in those areas are softening objectionable clauses rather than let expensive suites stand empty.

In any event, it will pay you to go over your lease line by line (preferably with a lawyer). Here are the main points to watch:

Description of premises. Make sure that the lease describes *com-*

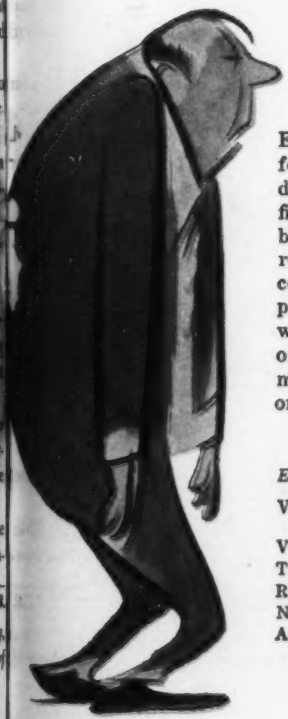
By Edward T. Welch, LL.B.

**The author, a New York attorney, is also president of the Society of Medical Jurisprudence.*

Sick people need nutritional support

specify **THERAGRAN**

Therapeutic Formula Vitamin Capsules Squibb



Even if an optimal diet is prescribed for — and eaten by — the sick person, diet alone will not correct vitamin deficiencies rapidly. Theragran will help bring earlier and more satisfactory recovery after surgery, will help to correct dietary deficiencies among patients who are "bad eaters," and will add greatly to the effectiveness of the therapeutic and supportive measures in patients who are older or chronically ill.

Each Theragran Capsule contains:

Vitamin A (synthetic)	25,000 U.S.P. units
Vitamin D	1,000 U.S.P. units
Thiamine Mononitrate	10 mg.
Riboflavin	5 mg.
Niacinamide	150 mg.
Ascorbic Acid	150 mg.

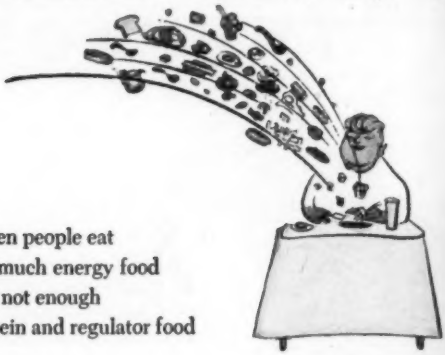
Bottles of 30, 100 and 1,000

see following pages . . .

SQUIBB

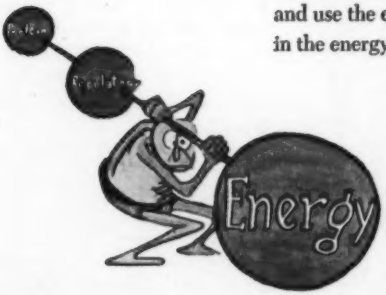
"Diet Instructions" your patients' guide to better diet

You need to watch what you eat



When people eat
too much energy food
and not enough
protein and regulator food

...they do not get enough
protein, vitamins and minerals,
which they need to keep well
and use the energy
in the energy foods.



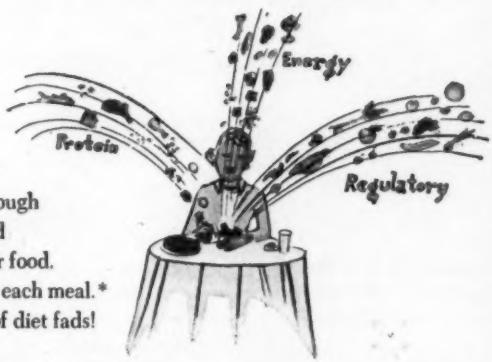
Then they may
need large quant
of protein,
vitamins or mine
to get well.

...see preceding page

This is a reproduction of pages 6-7 from "Diet Instructions," a new practical guide to better diet for your patients. For a supply of booklets write to E. R. Squibb & Sons, 745 Fifth Avenue, New York 22, N. Y.

see following page . . .

You need to watch what you eat



You must eat enough protein food, and enough regulator food. Try to do this at each meal.* Avoid all kinds of diet fads!

*You may eat food hot or cold, raw or cooked, fresh or frozen, canned or dried, unless special instructions are given.

protein foods

energy foods

regulator foods

SQUIBB

"Diet Instructions" show your patients how much is enough

Toast and coffee isn't enough to start the day on. It's better to add vegetable or fruit juice and an egg.

A small piece of meat doesn't give you enough protein. Increase the size of the portion of meat, or also eat some other protein food, or drink milk.

A small dish of string beans isn't enough. Better take a larger serving ... or add a salad.

A lettuce leaf and slice of tomato doesn't really count. You need more regulator food ... such as raw cauliflower chunks, sliced carrots, or cucumber rings.

"Diet Instructions" is the new simply written guide to better eating habits for your patients. To obtain a supply just write to E. R. Squibb & Sons, 745 Fifth Avenue, New York 22, N. Y.

... see preceding pages

SQUIBB

pletely what you're getting for your rent money. Besides listing the rooms included, it should mention any space you've been promised in basements, attic, garage, or grounds. If you're renting furnished quarters, it should describe the furnishings accurately. Some landlords aren't above using expensive draperies and furniture as bait to catch an unwary tenant; then, as soon as they have the tenant hooked, they replace the good furniture with secondhand relics.

Heat, Gas and Light

Your lease should also stipulate what services the landlord is to provide. If he's to pay for heat, gas, and electricity, let him put it into writing. And unless you care to risk paying for repairs to worn-out plumbing and leaky roofs, have it stated that he's to keep the premises habitable.

Another thing: Unless you've covered the point in your lease, don't take it for granted that your landlord will continue to provide all the services he's provided previously. The owner of a large apartment building, for example, had for almost twenty years operated a free school-bus service for his tenants' children. A number of tenants probably would-n't have taken their apartments without the promise of this service. Yet they didn't have a leg to stand on, legally, when the landlord suddenly stopped running the busses. In court, he denied that any such service had been promised. And since the leases made no mention of school busses, the court held that the service had been "merely a voluntary concession . . . and thus subject to recall."

Alterations. No matter how adequate your office seems when you move in, you'll probably want to make changes as time goes by. So it's a good idea to write into your lease (1) the extent to which you may alter the premises; and (2) who's to pay for any special plumbing, gas, and electrical work that you require.

If you expect to install any equipment, stipulate that you can take it with you when you leave. Otherwise you may find yourself in the same boat with a doctor who had a pedal-controlled sink and some expensive cabinets installed, and then had to leave them behind when his lease expired.

Before you sign a lease—and *certainly* before you start knocking down walls—make certain that you won't have to restore the premises to their original condition when you move out. One medical man put a laboratory, a darkroom, and other special features in space he rented in a private home. When his lease expired, he was presented with a bill for $1,500. It would cost that much, said the landlord, to fix up the rooms the way they'd been before.

Escape clauses. Try to get unrestricted privilege to assign or sublet —or, at least, suggest a clause like

through i-n-t-e-r-r-u-p-t-e-d RUTOL therapy

Goodman and Gilman* stress the importance of assuring continuous response to nitrite medication by: (1) "Employing the smallest effective dose to initiate therapy, so that . . ." (2) "the dosage may be increased as tolerance develops" and (3) "cessation of administration of nitrites for several days" to reestablish "the original degree of susceptibility . . ."

RUTOL

Suggested Rx Cyclic Regimen

1 One Rutol Tablet after each meal and at night, for 2 weeks.

2 Two Rutol Tablets q.i.d., for 1 week.

3 Use alternate medication for two weeks, returning to Rutol as before.

(Pitman-Moore Brand of Rutin, Phenobarbital and Mannitol Hexanitrate)

—combines mannitol hexanitrate in suggested small dosage, 16 mg. (¼ gr.); phenobarbital, 8 mg. (⅛ gr.)—sufficient to be effective without danger of over-sedation; rutin, 10 mg. (⅙ gr. approx.) to help safeguard against capillary fragility.

PITMAN-MOORE COMPANY
Pharmaceutical and Biological Chemists
Division of Allied Laboratories, Inc.
Indianapolis 6, Indiana

*Goodman, L., and Gilman, A.: *The Pharmacological Basis of Therapeutics*, New York, The Macmillan Co., 1941.

this: "The tenant shall not assign . . . without the landlord's consent, but such consent shall not be unreasonably withheld." Not long ago, a Southern physician, forced by ill health to put his practice on the market, learned the hard way that he couldn't sublet without his landlord's consent. He got the consent, all right—after he'd given the landlord $2,000.

Another doctor decided to offset part of the cost of his high-rent office by subletting it to a colleague during the mornings. His landlord, on hearing of the plan, pointed to a clause in the lease which forbade his subletting "any portion" of the premises without written consent. Seeing that the consent wasn't to be had cheaply, the M.D. gave up his idea. There would have been no problem if his lease had simply stated that "the tenant shall not sublet the demised premises without the written consent of the landlord." Where the wording runs like this, the courts have ruled that subletting on a part-time basis (or subletting part of an office) is permissible.

If you can't get unrestricted privilege to assign, try to win the right to terminate the lease if you must move for professional or health reasons—or if you're called into service. A young New Jersey physician, tapped by Uncle Sam last year, had to pay four months' rent—over $500—to get out of his lease. At that, he considered himself lucky; a *really* mean landlord might have extracted payment for the twenty unexpired months of his term.

While you're at it, specify that you're to be relieved of further liability as soon as you've assigned your lease. Otherwise you may wind up guaranteeing your assignee's obligations.

When a Lease Expires

Renewals. Obviously, it's worth your while to get an option to renew your lease. But the important thing about renewal clauses is not only *what* they say but whether *you know* what they say.

Sometimes, for example, a lease is renewed by written notice on or before a certain date; sometimes it's renewed automatically by failure to give notice. If, in the latter case, you neglect to give notice before a specified date, you risk being held liable for an additional term's rent.

Another thing: Your lease may be extended if you fail to move out on or before the expiration date. Because he was two weeks late in vacating, one M.D.-tenant had to pay rent for another full year.

Here are some other points to remember about leases:

¶ Chances are, your lease will contain a "viewing clause" giving your landlord the privilege of showing the place to prospects for a specified period before your term runs out. To minimize this nuisance, try to hold the viewing period to a reasonable length of time—say, thirty days. [*Turn page*]

bed-pan patients needn't offend . . .

Chloresium chlorophyll tablets

effectively suppress objectionable odors

Well known for its unique ability to deodorize foul-smelling lesions when applied *topically*, CHLORESIUM Chlorophyll provides an effective solution to a particularly distressing odor problem when administered *orally*. In a recent study[1] on colostomy patients, it was found that "within forty-eight hours there was a striking reduction in objectionable odor, to the gratification of not only the patients themselves but also of staff members and other patients in the ward and adjoining beds."

Initial dosage of two tablets four times daily, then one tablet four times daily, is usually sufficient to control bed-pan or colostomy odors.

in mouth, breath and body odors, CHLORESIUM's concentrated highly purified water-soluble chlorophyll provides simple, economical, yet effective deodorization. Prescribe CHLORESIUM TABLETS whenever odor control is indicated. Average dose one tablet daily.

supplied: boxes of 30 tablets, bottles of 100 and 1,000.

1. Weingarten, M., and Payson, B.: Deodorization of Colostomies with Chlorophyll, Rev. Gastroenterol. *18*:602, 1951.

Rystan company inc., MOUNT VERNON, NEW YO

¶ If you're renting space that was previously residential, check to make sure that the practice of medicine isn't prohibited there by zoning laws or restrictions in the deed. If possible, have the landlord warrant that the practice of medicine is legal in that space. And if you plan to keep laboratory animals on the premises, better make sure that they'll be allowed.

¶ In some states, unjust though it seems, you may have to keep on paying rent if your office is destroyed by fire. To guard against this possibility, better tack on a protective clause at lease-signing time.

¶ If possible, stipulate that the landlord is to assume all liability to anyone injured on the premises. Otherwise *you* may have to foot the bill if, for example, a patient trips on a raised floor board. Of course, the owner of a multiple-unit building is liable for injuries caused by defects in common stairways, entrances, and the like. But he's generally under no legal obligation to search a tenant's quarters for defects. END

Comedy of Errors began when Dr. Dayton O'Donnell boarded a plane in Detroit. He was bound for a medical meeting in Cleveland; but bad weather caused a long detour and a landing in Charlotte, N.C. Lacking enough cash to get home, he decided to push on to Miami and borrow travel money from an old friend who owns Miami's Golden Strand Hotel. This second flight was punctuated by a fire in mid-air: It seems that Dr. O'Donnell, while pondering his dilemma, had thrust a lighted pipe into his overcoat pocket, thus starting a lively blaze. The photo shows him in Miami, armed (with fire extinguisher and greenbacks) against further travel hazards, and about to start back to his surgical practice in Detroit. The return flight, he reports, was singularly dull.

Are You Campaigning Legally?

Here are some legal cues for your '52 politicking, with a special note for those who work for Uncle

• Already the donkey is braying and the elephant is trumpeting. The political ramparts are rising for what may be one of the liveliest national election years in a long while.

Once again, the nation's doctors —along with everyone else—are rooting for their favorite candidates. Many will want to work for their candidates, too, as well as vote for them.

But while taking a stand on the office-seeker of his choice (and exhorting friends and patients to do the same), the physician must be careful not to tread on the law. He must remember that all men at campaign time are bound by the little-known provisions of the Hatch Act and the Corrupt Practices Act, both of which place restrictions on "political management and political activity."

Listed on the following pages are some basic prohibitions of these laws. Listed there too—and perhaps even more important—are the positive sections of the law—those telling what you *may* do.

Note well: These ground rules apply only to Federal political activity. Each state, additionally, has its own set of campaign statutes; and in some cases, the state laws are stricter than the Federal ones. So if you're backing a candidate for a state or municipal office, get local legal advice before going into action.

Since 1950, when Federal restrictions on political activity were interpreted for the medical profession by the legal firm of Kirkland, Fleming, Green, Martin & Ellis, at the request of Whitaker & Baxter, a new wrinkle has developed. The result is that many more physicians will be enjoined from political activity this year than in previous election years. Chiefly affected are those who perform services for Government-financed agencies on a part-time salaried or per diem basis.

Previously, it was well established that a physician on full-time service with a Federal agency or with a Federally financed state or municipal agency could not legally thump for a Presidential, Congressional, or other Federal office-seeker. But un-

---

By James G. Blake

Individualizi

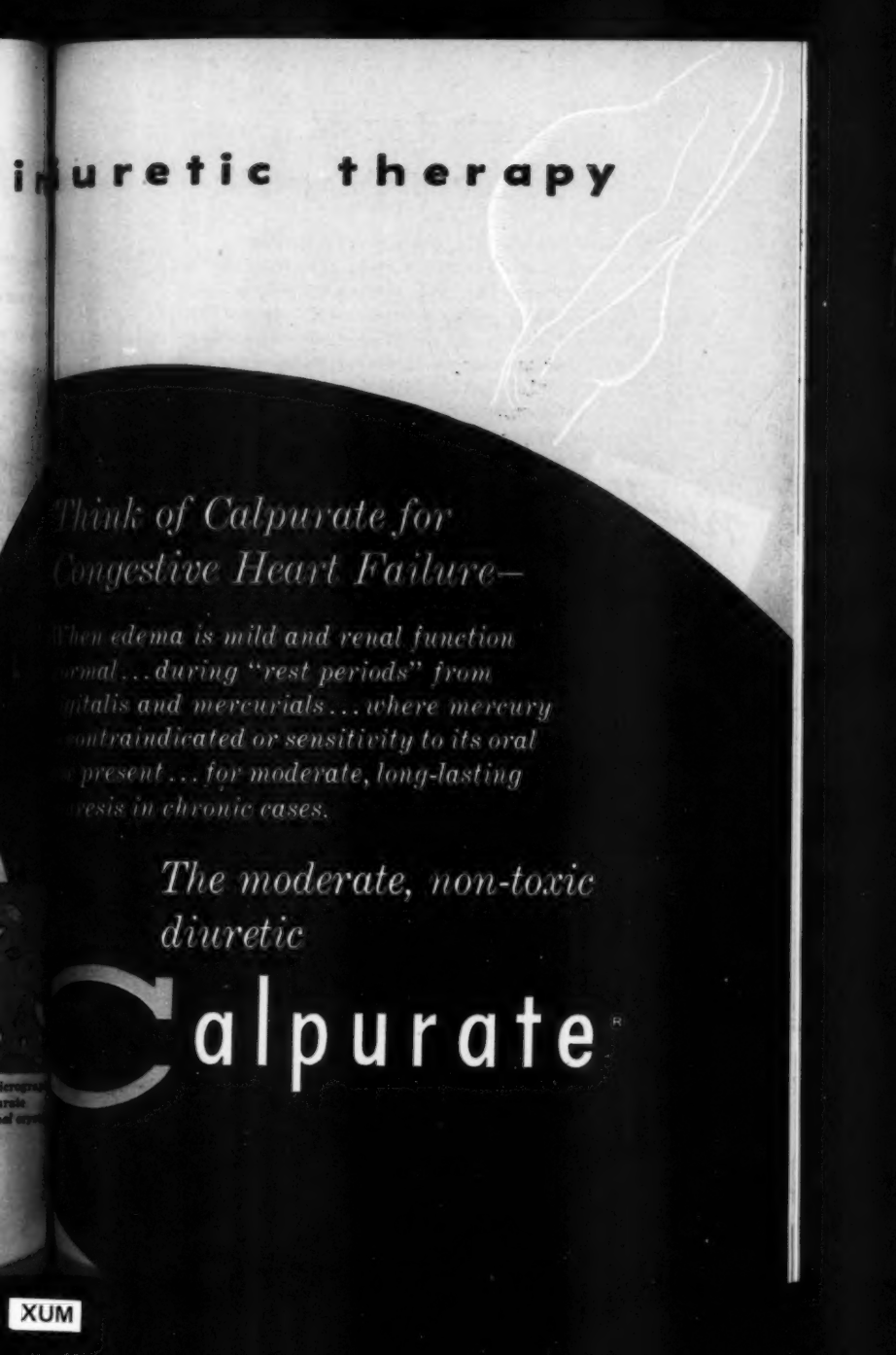
The most suitable diuretic—carefully selected for each edematous patient—will not only diminish invalidism... it will add greatly to the extension of life. It is the backbone of today's therapy, along with rest, digitalization and salt restriction.

Calpurate is the crystalline compound—theobromine calcium gluconate—distinguished for its moderate diuretic action and minimal toxicity. It is remarkably free from gastro-intestinal and other side-effects, and does not contain the sodium ion.

Calpurate is also helpful in other cardiac conditions because it stimulates cardiac output. *Calpurate with Phenobarbital* is useful in relieving anxiety and tension, as in cases of hypertension. Calpurate, supplied as Tablets (500 mg.) and Powder; Calpurate with Phenobarbital (16 mg.), as Tablets.

MALTBIE LABORATORIES, INC., NEWARK

Photomicrograph of Calpurate hexagonal cry


iuretic therapy
Think of Calpurate for
Congestive Heart Failure–
When edema is mild and renal function
rmal... during "rest periods" from
gitalis and mercurials... where mercury
ontraindicated or sensitivity to its oral
present... for moderate, long-lasting
resis in chronic cases.
The moderate, non-toxic
diuretic
Calpurate®

til recently, when a Federal court ruled on the question, it was not clear whether the per diem Government doctor was also restrained by the Hatch Act. The court's decision: He is.

Thus you're probably on the sidelines this year if you're employed—either full-time *or* part-time—by any of the following Federal agencies:

¶ The armed forces and their subdivisions;

¶ The Public Health Service;

¶ The Veterans Administration;

¶ "Any activity or project of the Federal Government that retains doctors for any consultative, advisory, research, or other professional

Election Laws Say 'NO!'

Whether you're in private practice or on salary, whether a medical association member or officer, the Federal law says you may not . . .

. . . **indulge in normal political activity** if you're compensated wholly or partly out of Federal funds. (See text.)

. . . **use medical society funds,** facilities, or letterheads for promoting the cause of any candidate.

. . . **reveal to a political candidate,** campaign manager, or political committee the names of any persons receiving relief money from the Government.

. . . **circulate anonymous pamphlets** or handbills. Names of the sponsors must appear on all campaign literature.

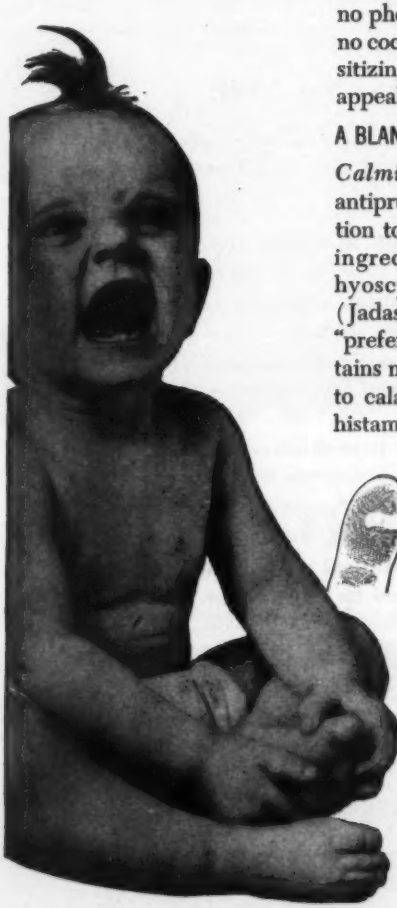
. . . **solicit contributions** from persons on relief or persons holding contracts with the Federal Government.

. . . **authorize or solicit political contributions** from any corporation, whether organized for profit or not. Your medical society is considered a corporation under the law.

. . . **promise financial or political support** to a candidate, if such support is conditioned on the stand he takes.

. . . **spend $50 or more** to influence elections in two or more states without reporting your expenditures to the Clerk of the House of Representatives.

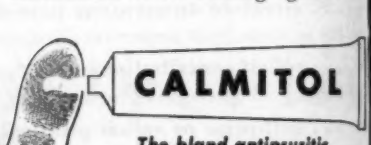
itching | handle with care



When the itching infant urgently needs relief, his tender skin must be "handled with care" and therefore— no phenol (as in calamine c̄ phenol), no cocaine, in fact no irritating or sensitizing agents. His loud and insistent appeal calls for

A BLAND AND EFFECTIVE RESPONSE

Calmitol Ointment affords potent antipruritic control (in contradistinction to calamine[1]) through its active ingredients camphorated chloral, hyoscyamine oleate and menthol (Jadassohn's Formula). *Calmitol* is "preferred"[2] for safety because it contains no phenol[3] (in contradistinction to calamine c̄ phenol) and no antihistaminics or sensitizing agents.



The bland antipruritic

1. Goodman, Herman: J.A.M.A. 129:707, 1945.
2. Lubowe, I. I.: New York State Journal of Medicine 50:1743, 1950.
3. Underwood, G. B., Gaul, L. E., Collins, E., and Mosby M.: J.A.M.A. 130:249, 1946.

Thos. Leeming & Co. Inc.

155 E. 44th St., New York 17, N. Y.

purpose." (Included here are the many M.D.'s who serve occasionally on Army or Navy inspection commissions.)

You also may be prohibited from campaigning if you're connected with state or local hospitals, health departments, schools, safety and sanitation commissions, highway departments, and the like *that receive any financial support from the Federal Government.*

Generally, if you're working part-time for any of the foregoing agencies, whether Federal or local, you're subject to the campaign laws only during the period of your "active employment." By the broadest interpretation of the law, this means that if you work for the Government

Election Laws Say 'O.K.'

If you observe the restrictions listed on page 107—and the special ones for doctors who do Government work—you may . . .

. . . **engage in active support of candidates** for Federal office, but only as an individual citizen—not under the auspices of your medical society, and not using your society title of office. (Make sure that your political activities don't coincide with a trip you may be taking for your medical society.)

. . . **help organize or take part** in the activities of a political committee that has been set up to accept contributions and to make expenditures aimed at influencing the election.

. . . **solicit and receive contributions** on behalf of any candidate—but you must give the treasurer of your political committee a written account of each gift within five days after receiving it.

. . . **manage a candidate's campaign** and participate in it by writing, speaking, or by otherwise advocating his election.

. . . **take part freely in registration drives** and get-out-the-vote campaigns.

. . . **personally contribute up to $5,000** to, or on behalf of, a candidate for Federal office.

. . . **take part in conventions,** rallies, mass meetings, and parades in behalf of a political candidate.

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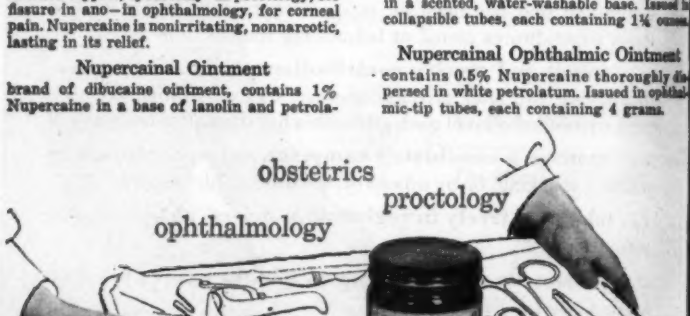
contains 0.5% Nupercaine thoroughly dispersed in white petrolatum. Issued in ophthalmic-tip tubes, each containing 4 grams.



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two days a month, you're legally bound only during those days. *But* note this:

If you have a contract and receive a retainer from a Government-supported agency, you're covered by the Federal laws during the entire period of your contract—no matter how seldom you're actively employed.

Happily, there are some exceptions to the statutes governing physicians who serve the Government. For example, you may be free to do some campaigning if:

1. You're retained to perform "special service" on a *fee basis* and have taken no oath of office;

2. You work for a religious, philanthropic, or cultural organization —even though the organization gets Federal money.

What specific things can't you do if you're compensated by one of the agencies affected by the law? The A.M.A.'s legal counsel explains that you may *not*:

¶ Become prominently identified with any political movement, party, or faction, or with the success or failure of any candidate;

¶ Perform service in or for any political committee, or even join one;

¶ Take active part in the management of any political club (although you may belong to one if you're not too influential);

¶ Take part in rallies, mass meetings, conventions, parades, and the like, in a capacity other than spectator (and even as a spectator you must not resort to "a public display of partisanship or demonstration");

¶ Wear campaign badges or buttons while at Government work;

¶ Have your wife campaign for you.

Anyhow, You Can Vote

But cheer up: The law does concede that the Government-service doctor has a right to vote as he pleases and to express his opinion (even though not too loudly).

If you're in doubt about whether you belong to any of the "prohibited" categories, it's best to be cautious. So extensive is the coverage of the Hatch Act that some legal authorities believe it applies even to physicians who work voluntarily for Federally supported agencies.

"Even if a doctor donates his time and is compensated only for expenses, I think the Government will contend that he is within the prohibitions of the law," one medico-legal expert has said.

How strict are the Federal political activity laws? You can get an idea from the penalties they carry: up to $10,000 in fines or five years in jail—or both. The stiffest penalties are specified by the Corrupt Practices Act.

Generally, violators of the Hatch Act, which is concerned almost entirely with Government employes, are not fined or imprisoned. But they do almost always lose their Government work. END

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5. Lability of blood pressure, so important in meeting the demands of an active life, is not interfered with; there is no danger of postural hypotension . . .
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What People Think About

The Sliding Scale of Fees

This city's physicians and laymen seem to favor it

• In the growing debate over sliding-scale fees vs. standardized fees, where do doctors and their patients really stand? Do they see eye to eye? Or are they on opposite sides of the fence?

Some revealing answers to these questions emerge from a comprehensive survey recently completed in Toledo, Ohio. Representative laymen and physicians were asked (among many other things) how they felt about the sliding scale of fees. Their responses indicated that:

¶ About four out of five doctors favor the sliding scale. The rest were dissatisfied with it, wanted standard fee schedules, or were uncertain.

¶ A majority (56 per cent) of the general public also favors the sliding scale. Only one out of four thought that doctors should charge all their patients the same. (The remaining respondents were in the "don't know" category.)

The Toledo survey was sponsored jointly by the Academy of Medicine of Toledo and Lucas County; by Wayne University, Detroit; and by the Health Information Foundation, New York.* It was designed to explore any differences of opinion between three elements of the community—the general public, the medical men, and the lay leaders in various fields.

A cross-section of the general public was interviewed first, using a detailed questionnaire. The respondents represented 590 families out of approximately 117,000 households in Toledo and Lucas County. Their views on fee setting were solicited thus: "In general, how do you feel about the way medical fees are determined?"

Most of them didn't know what to say. In fact, 77 per cent fell into the "don't know" or "no response" column. Obviously, they weren't sure *how* fees are set.

Their opinions came into sharper focus when the next question was asked: "Do you think doctors should

*The complete survey report, to be published next month, is the work of Edgar A. Schuler, Robert J. Mowitz, and Albert J. Mayer of the Wayne University faculty. Copies will be available from the Health Information Foundation, 420 Lexington Ave., New York 17, N.Y.

By James C. Fuller

charge the same fee for everyone, regardless of income, or should they charge different people different fees?"

Not surprisingly, those in the under-$2,000 income group plumped strongest (63 per cent) for variable fees. But in all the income groups from $2,000 on up, a majority wanted the sliding scale.

The community leaders interviewed totaled thirty-eight, and they were interviewed at much greater length—sometimes for several hours. When they were asked to discuss medical fee setting, a good deal of criticism was revealed. In fact, nineteen of the thirty-eight voiced serious objections to the way doctors were handling it. This critical group included leaders in business, labor, politics, journalism, welfare, and religion.

What were they disturbed about? Mostly, about seemingly capricious fee setting and about fees that slide upward too far. For example:

"Why should the same operation cost different individuals a different amount of money?" a labor leader asked. Another leading citizen complained: "Fees are set to take all that the traffic will bear, and perhaps a bit more."

Are well-to-do people happy about their treatment under sliding scale fees? Not at all, declared one leader who's connected with hospital administration. "Very wealthy people," he told the interviewer, "are extremely bitter toward the sliding scale that requires them to pay much

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higher fees than those with moderate incomes."

His recommendation: Let people in on what to expect as a standard fee. Then they can judge better whether doctors are treating them fairly.

The Toledo survey reflected growing public awareness (at least among lay leaders) of the standard fee allowances paid by health insurance plans. It was these fixed payments for certain medical services that the labor leader, quoted above, was using as his criterion. In objecting to variable fees for the same operation among union members, he pointed out:

"These variations in fees don't reflect any sliding scale based on income. Our union members, for the most part, are in the same income group."

He and another labor leader also charged that physicians "jack up prices" when they learn that their union patients are covered by surgical indemnity plans. Several other community leaders deplored the tendency of some physicians to regard the patient's Blue Shield protection as evidence of increased ability to pay higher fees.

One man, for example, cited a case where the physician charged double his usual fee for an operation on a patient with Blue Shield coverage. Another leader declared flatly: "Any physician who charges twice as much as Blue Shield provides for an operation is charging excessive fees." Thus went the criticism of the sliding scale.

Few lay leaders actually suggested that the doctors stick exclusively to standard fees. Their major gripes, however, clearly centered around misuse of the sliding-scale principle. One man volunteered the opinion that "5 per cent of the physicians cause about 90 per cent of the trouble."

Toledo doctors were the last group to be interviewed. They included fifty-four G.P's and specialists, selected at random from the 535 medical men in active practice locally. Toward the end of each interview, the subject of sliding-scale fees was broached thus: "In some of our interviews with local leaders, we've gained the impression that there is considerable feeling about the sliding scale for setting fees. What do *you* think about it?"

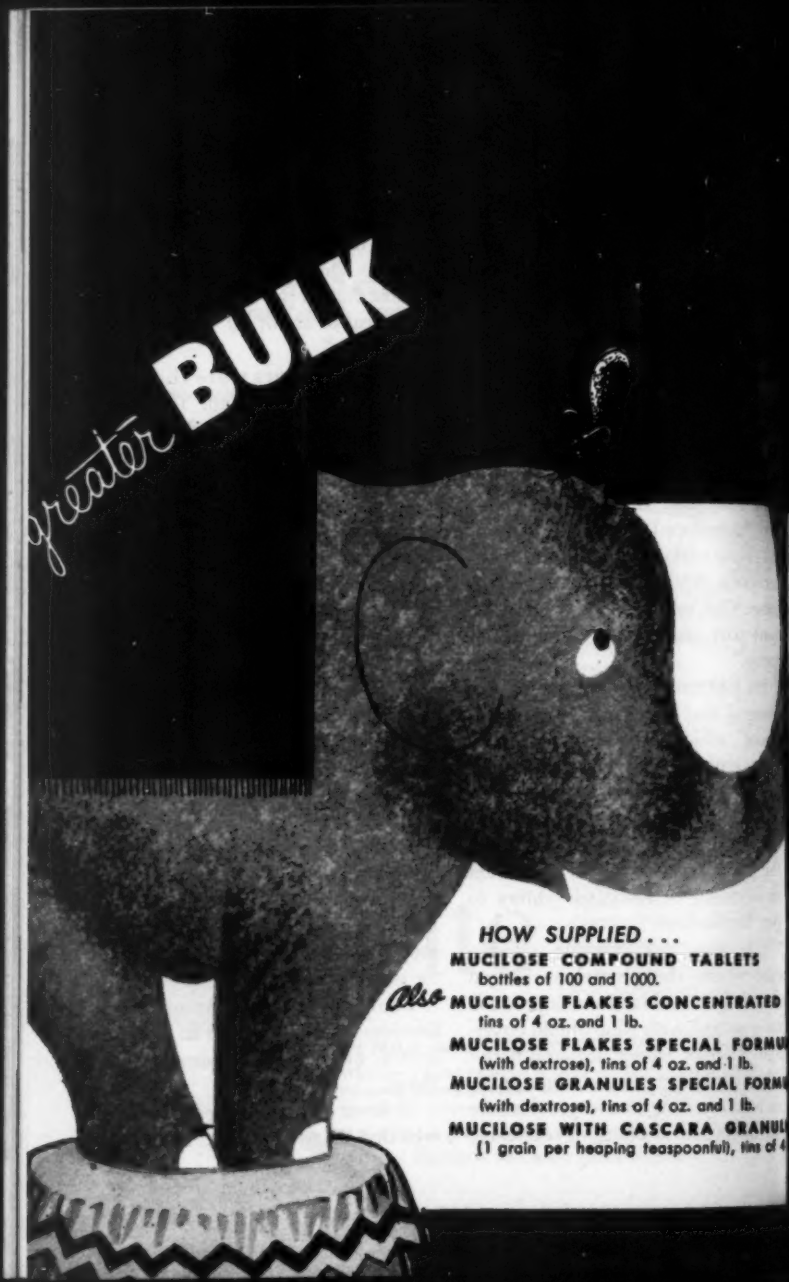
That's when four out of five doctors spoke up in favor of the sliding scale. Why did they like it?

Sliding Fees Up

Many, of course, considered the flexibility essential to allow for patients who can pay little or nothing. But some felt frankly that they should also be at liberty to raise fees for wealthy patients.

From the M.D.'s who wanted freedom to slide fees up as well as down, came such comments as these:

"I favor the sliding scale for the wealthy. They expect it. They pay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more for maids, cars, etc. It has always been that way."

"I think well-to-do people realize that there is much more risk to the doctor's reputation if anything goes wrong with an operation in their family than if the patient is a charity case. Same operation, same care. But if it's Mr. Gotrocks, everybody would know about it. If it's Joe Doakes, nobody would know. That's really the only legitimate reason for differences in fees."

On the other hand, some doctors who voted for flexible fees added such comments as these: "I don't believe it's fair to soak the rich" ... "I don't believe in overcharging simply because somebody has more cash."

Probably the best reflection of the Toledo doctors' attitude is contained in this man's remark: "I favor the sliding scale. One case may look the same as another case, but may actually require differences in service. However, I don't believe *big* differences in fees are advisable."

Sliding Fees Down

Does this preference for sliding-scale fees rule out standardized fee schedules? Not necessarily, according to some doctors—provided that you can still scale fees downward. Several who endorsed flexible fees reported nevertheless that they used the workmen's compensation fee schedule as "a kind of baseline to work from." And as one M.D. explained: "For people in the lower income brackets, I even undercut that."

[*Turn page*]

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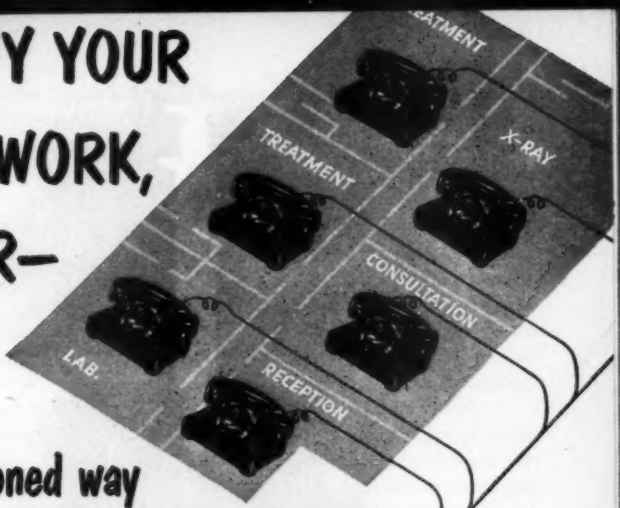

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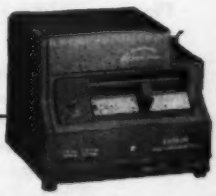

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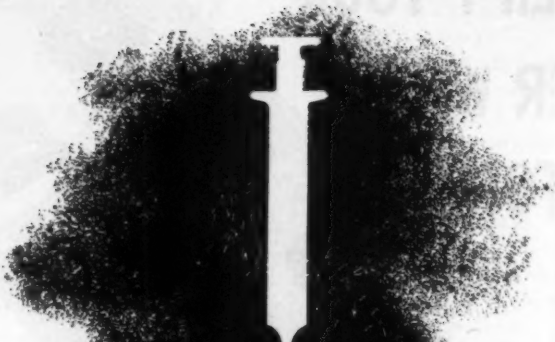

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Few doctors were as uncompromising as the one who told his interviewer: "Establishment of set fees is fundamentally wrong. It's just what we don't want. Fees apply to too wide a spectrum of individuals to be fixed arbitrarily. And fees are set by a wide spectrum of doctors with different training and qualifications."

What about public resentment over the sliding scale? Like the lay leaders, the doctors were inclined to blame the mercenary few in the profession.

One physician held that it's mainly the surgeons who have abused the sliding-scale principle. Surgeons, he said, "have boosted their fees all out of proportion to what the general man charges." They have thus "led to this beefing by the public."

"This business of fees is the most ticklish part of practicing medicine," remarked another Toledo doctor. And whether you lean toward standardized or sliding-scale fees, you'll probably go along with the following comment from one of the youngest practitioners interviewed:

"I still think that the fee problem is one of the *greatest* problems that American medicine has to overcome, if we desire to maintain our present status." END

"It's no trouble at all, Mrs. Smith. I've another call to make near here, so I'm really killing two birds with one stone."

If your summer plans include

A Business-and-Pleasure Trip Abroad

Then this slate of meetings is for you

• Thinking of combining your vacation this year with attendance at one or more medical conventions abroad? If you are, you may find the following list of summer meetings useful.

Since some of the expenses that you incur in attending these conventions may be a legitimate income-tax deduction, better remember to keep a written, itemized account of all your professional outlays.

When	*What*	*Where*	*Information Source*
June 9-13	Canadian Medical Assn.	Banff, Canada	Dr. T. C. Routley 135 St. Clair Ave. W. Toronto, 5
July 7-11	British Medical Assn. and Irish Medical Assn.: Joint Annual Meeting	Dublin, Ireland	British Medical Association Tavistock Sq. London, W.C.1
July 7-12	International Diabetes Federation Congress	Leyden, Netherlands	Dr. F. Gerritzen 33 Prinsegracht The Hague, Neth.
July 8-13	Commonwealth and Empire Health and Tuberculosis Conference	London, England	Dr. J. H. Harley Williams Tavistock House N. Tavistock Sq. London, W.C.1
July 14-19	International Congress of Physical Medicine	London, England	Dr. A. C. Boyle 45 Lincoln Inn Fields London, W.C.2
July 21-26	International Congress of Dermatology & Syphilology	London, England	Dr. G. B. Mitchell-Heggs 5 Lisle St. London, W.C.2

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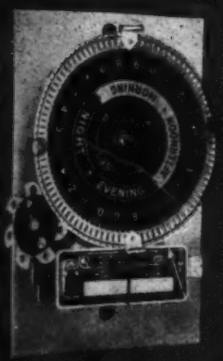

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A Business and Pleasure Trip Abroad *(Cont.)*

When	*What*	*Where*	*Information Source*
July 21-27	International Congress of Biochemistry	Paris, France	Prof. Jean Courtois 4, avenue de l'Observatoire Paris, 6è
August	Congress of International Institute of Embryology	Utrecht, Netherlands	Prof. Dr. C. P. Raven Hubrecht Laboratory Janskerkhof 2 Utrecht, Netherlands
Aug. 24-27	Conference of the International Union Against Tuberculosis	Rio de Janeiro, Brazil	Prof. Etienne Bernard 66, blvd. St. Michel Paris, 6è
Aug. 31-Sept. 7	Inter-American Cardiological Congress	Buenos Aires, Argentina	Dr. Blas Moia Larrea 1132 Buenos Aires
Sept. 8-13	International Congress on Neuropathology	Rome, Italy	Dr. Armando Ferraro 722 W. 168 St. New York
Sept. 8-12	International Congress of Medical Sciences	Cannes, France	Dr. J. F. Delafresnaye 19, avenue Kléber Paris
Sept. 8-18	International Society of the History of Medicine	Nice-Cannes-Monaco, France	Dr. F. A. Sondervorst 124, avenue des Alliés Louvain, Belgium
Sept. 15-18	International Congress of Internal Medicine	London, England	Sir Harold Boldero Royal College of Physicians 12 Pall Mall East London, S.W.1
Sept. 21-26	Congress of International Society of Hematology	Mar-del-Plata, Argentina	Dr. Carlos Reussi Anchorena 1710 Buenos Aires
September	Medical Women's International Assn. Congress	Vichy, France	Dr. Ada C. Reid 118 Riverside Dr. New York
Oct. 12-16	World Medical Assn.: Sixth General Assembly	Athens, Greece	Dr. Louis H. Bauer 2 E. 103 St. New York 29 END

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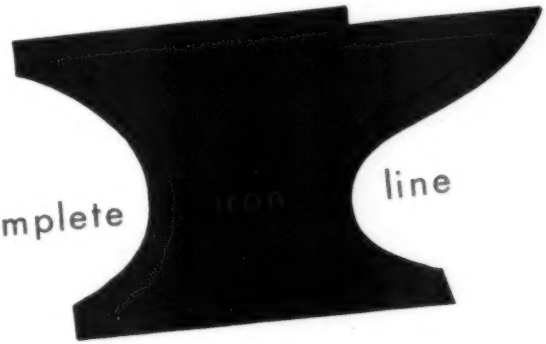

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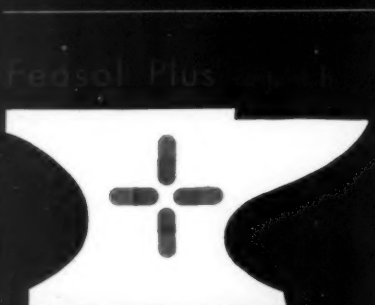

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One night about a year ago, James A. Waggener, field secretary of the Indiana State Medical Association, was spending a typical evening out. Some seventy miles from home, he was calling on doctors, talking over medical problems with civic leaders, and later sitting in on a session of the local TB group.

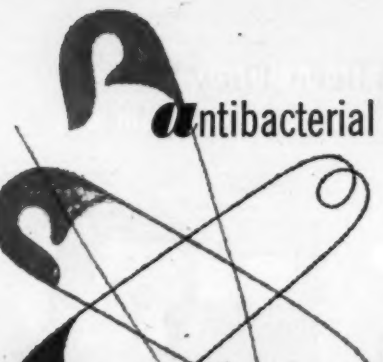
After the meeting, he was about to start home when a group of local doctors took him aside. They had a bone to pick:

For some time, they'd been under pressure to pay their $25 A.M.A. dues. As yet, not a single member of their county society had paid. What's more, none intended to. "What for?" the indignant doctors wanted to know. "What do *we* get out of it?"

A good listener, Waggener waited until all complaints were in. Then, he recalls, "I unwound. I must have talked for ten minutes on what organized medicine means to doctors." When he'd finished, one man shook

By James Fuller

As liaison man between doctors and the public, a medical society field secretary has to keep on the move. Indiana's Jim Waggener formerly clocked 3,000 miles every month.



Antibacterial Bactine

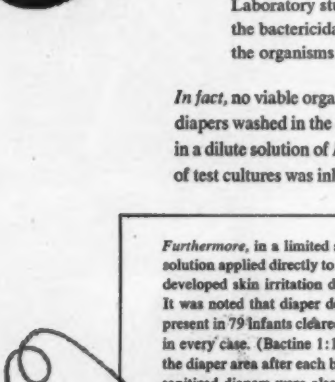
BRAND · Reg. U. S. Pat. Off.

combats diaper dermatitis

Laboratory studies have demonstrated the bactericidal power of *Bactine* against the organisms causing diaper dermatitis.

In fact, no viable organisms were recovered from diapers washed in the ordinary way and then rinsed in a dilute solution of *Bactine*. Even the growth of test cultures was inhibited on the diaper surface.

Furthermore, in a limited study of the gentleness of *Bactine* solution applied directly to the skin, not one of 100 babies developed skin irritation during 1 to 6 months' use. It was noted that diaper dermatitis or erythema already present in 79 infants cleared up within 2 to 7 days in every case. (Bactine 1:100 dilution was used to cleanse the diaper area after each bowel movement. *Bactine*-sanitized diapers were also used for 74 of the babies.)



Directions for sanitizing diapers — Use one teaspoonful of *Bactine* to each pint of water. Soak *clean* diapers in this solution for 3 minutes and dry. Use a fresh solution for each set of diapers.

Bactine: 1-gallon, 1-pint, 6-ounce and 1¾-ounce bottles. From your regular supplier, or we will assist you in ordering.

MILES LABORATORIES, INC · ELKHART, INDIANA, U.S.A.

his hand and remarked: "Thanks. I never thought about it that way."

A few days later, the local society sent in A.M.A. dues for every one of its members.

This episode indicates the double value of a good field man. Sure, he helps the medical society; but he also helps individual doctors by serving as an on-the-spot interpreter of its actions. "Regardless of how good our society programs appear to be," Waggener says, "they aren't worth a continental if local physicians don't know the why of them."

Moreover, he adds, many doctors harbor the belief that their medical society is autocratic, that members aren't consulted enough. Such men generally won't bother to sound off at long distance to headquarters officials. But they will confide in a field man when he's on the spot, Waggener has found.

Similarly, lay people hesitate to register official complaints with the medical society about such things as the doctors' night-call service or the doctors' non-participation in local health programs. Yet such people feel free to tell it to another layman —the field secretary.

Not long ago, Waggener visited an Indiana city of 30,000 and found its only newspaper locked in a bitter feud with the local hospital. The trouble had started when a reporter and a photographer forced their way in to get an unauthorized story. In retaliation, hospital officials clamped down on all news originating in the hospital. So the newspaper began to take editorial pot-shots at the hospital and everyone connected with it, including local medical men.

Unable to effect mediation by just listening and talking, Waggener moved behind the scenes. He played an important part in getting the newspaper's owner named to the hospital's board of directors. Shortly afterward, the two warring factions patched up their differences and worked out a press code. Today the newspaper is energetically boosting the hospital and local physicians.

But trouble shooting is only part of a field man's job. What else does he do? Is it worth the cost ($12,000 to $15,000 yearly, in Indiana)? And what kind of man makes a topnotch field secretary?

Now that he has been elevated to the post of executive secretary, Indiana's Jim Waggener can look back objectively at his thirty months in

"At first I thought it was just earthquakes."

one of medicine's newest jobs. And through his experience, you can get some idea of the answers.

For sixteen years before he went to work for doctors, Waggener was advertising and business manager of the Franklin (Ind.) Evening Star. It was Franklin's need for a hospital that first pitched him into the medical field. A new Army camp was due; it would double the county's population and strain its health facilities. Franklin had no hospital and, at an emergency meeting of townspeople, Waggener asked, "What about it?" He was promptly given the job of getting one built.

After fighting unsuccessfully for Government funds, Jim decided: "We'll do the job ourselves." His newspaper ran editorial appeals until $500,000 had been raised. When Franklin's 65-bed hospital opened in 1945, Waggener was named secretary of its board of trustees.

Soon a new worry faced him: How could the hospital pay its way without becoming a tax burden? Blue Cross seemed to be a good answer—insurance for hospital and patients alike. Not long afterward, the Indiana Blue Cross plan was persuaded to put on its first countywide enrollment campaign—with Waggener steering it. He didn't let up until a majority in the county had enrolled.

Impressed by this sort of action, Blue Cross officials hired Waggener as their state public relations director. But by 1948 another Hoosier, Oscar Ewing, was promoting a Federal brand of health insurance. When Indiana doctors decided to fight it, they picked Waggener to spearhead their campaign. They created the post of field secretary for him, in the spring of 1949, and told him to get humping.

By the end of this campaign, Waggener could report that 2,500 Indiana organizations, representing half the state's population, had been induced to send anti-compulsion resolutions to Washington. "Indiana Congressmen finally appealed to us to call off the campaign," he recalls. "By that time they were all on our side." Today, of 10,000 U.S. organizations on record against socialized medicine, one out of five has an Indiana address.

Field Man's Duties

With this achievement behind him, Waggener could turn his attention to the non-emergent duties of a field secretary. And just what is a field secretary?

"I honestly don't know," he confesses. "That is the title they gave me and I never questioned it. I just pitched in and did whatever I could to help out. But I do know that the *field* part of the title is an after-hours job. The *secretary* part eats up most of the day—committee meetings, public relations work, and such."

"After work," during his last eighteen months as field secretary, Waggener drove 50,000 miles in his car. Besides attending local medical

meetings, he'd take in meetings of public health, civic, and related professional groups. Many nights this meant driving one or two hundred miles before jumping into bed for a few hours' sleep. "Doctors don't keep regular hours," remarks Waggener, "so I didn't either."

Field service à la Waggener seems to comprise two main efforts: (1) *inside the profession* through personal contact with medical societies and individual doctors; and (2) *outside the profession* through personal contact with laymen and civic groups to improve their ties with physicians.

A job to be done may turn up almost anywhere. Once, while covering a legislative session, Waggener was buttonholed by several labor leaders who had a grievance against doctors. Indiana M.D.'s, they charged, were hamstringing workmen's compensation hearings: The physicians weren't showing up to give testimony.

This was the field man's cue to spur medical society action. The society's industrial health committee called a parley that included representatives of medicine, labor, law, and government. They soon rooted out the trouble: Failure to testify at hearings, they found, was usually due to legal delays and improper notification. Few physicians were avoiding their responsibilities, as charged. The upshot: full agreement on improved methods of conducting industrial hearings.

School health planners are apt to be of special importance to doctors. Not long ago, Waggener says, "I got a little tired of hearing the profession criticized for its attitude toward such programs." Local doctors were not at all clear about their school health responsibilities—but neither were school officials.

So last fall, Indiana held its first statewide school health conference. Instigator: the state society's school health committee, of which Waggener is secretary. Today a permanent committee named by this conference is setting up uniform health programs and standards for all grades of Indiana public schools. In the process, it is more clearly defining the local doctors' job.

A similar strategy can be applied

"You're not getting enough green stuff. And the way you ignore my monthly statements, neither am I."

Enteric Antimicrobia

Sharp & Dohme

Cremos

ia Detoxicant, Adsorbent

CREMOSUXIDINE®, delicious, chocolate-mint flavored, creamy suspension of SULFASUXIDINE® succinylsulfathiazole, pectin and kaolin, controls infectious and non-specific diarrhea in three important ways. A potent enteric antimicrobial, SULFASUXIDINE reduces intestinal bacterial flora; pectin forms nontoxic conjugation products; kaolin adsorbs toxins and irritants, helps form stools of normal consistency. Each tablespoonful of CREMOSUXIDINE contains SULFASUXIDINE, 1.5 Gm., Kaolin, 1.5 Gm., and Pectin, 1%. SPASAVER® bottles of 16 fluidounces.
Sharp & Dohme, Philadelphia 1, Pa.

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Sulfasuxidine® Suspension with Pectin and Kaolin

to combat rural grievances. Last year, the Indiana association's rural health committee (James A. Waggener, secretary) organized five regional meetings. At each of these, state medical leaders listened to the troubles of civic leaders, county nurses, farm bureau officials, and physicians. Now a rural health program is being formulated with grassroots cooperation.

For direct service to the physician himself, Waggener's No. 1 achievement as field secretary was probably Indiana's post-graduate programs by telephone. Now in their second year, these hour-long medical seminars are beamed monthly to M.D.-audiences at nearly half the county societies in the state. As a result of this program's success, Waggener reports, similar projects are being started up by Texas and Kentucky doctors.

Does Waggener think a field secretary really pays his way? "He can be a good investment," replies Waggener, "or he can be a dead expense. It depends upon the individual and the medical society. In areas of any size, however, I'd say that one or more field men can do a valuable job. And it's the sort of job that practicing physicians simply don't have time to do."

By way of emphasis, Jim Waggener (who has a wife and two daughters) adds with a grin: "It's a good thing I was married several years before getting into this work. I wouldn't have had time for courting if I'd waited!" END

"The hormones worked fine, Doctor. Now I need more vitamins."

Letters to a Doctor's Secretary

How to learn medical terms by making little words out of big ones

Dear Mary:

You ask me what you can do to speed your understanding of "those awful, jaw-breaking medical words." Actually they aren't as difficult as they look, once you realize that they're long only because each one is made up of several shorter elements run together.

Let me explain:

Most medical words are constructed according to a pattern, with the separate parts of each word derived almost always from Greek or Latin. They have a root that shows what they relate to (usually a part or process of the body). Then they have a prefix or suffix (or both) that tells something about the root.

Thus, *menopause* means *cessation* (-pause) of the *monthly* (meno-). *Amenorrhea* means *no* (a-) *monthly* (meno-) *flow* (-rrhea). *Dysmenorrhea* means *difficult* (dys-) *monthly flow*.

Take a look now at the table I've worked out for you (on pages 144-145). This gives a fairly complete list of the roots, prefixes, and suffixes from which most medical words are built. In constructing the complete word, a vowel (usually *a*, *i*, or *o*) is often put in between the parts to make the word pronounceable.

By using this table, you can easily dissect the unfamiliar medical words you run across. First find the meaning of each part of the word from the table. Then put them together and you have the meaning of the whole word. Doing this will help you remember them, too.

For example, take the disease *endocarditis*. Divide it up and you have: *endo* (within)—*cardi* (heart) —*itis* (inflammation). In short, inflammation within the heart.

In the same way, you can deal with *encephalitis* (*inflammation* of

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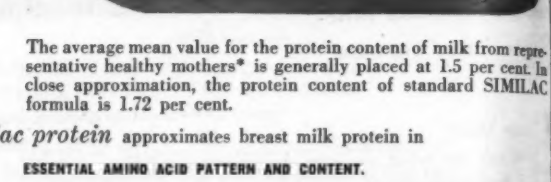
These letters were published originally as a series in MEDICAL ECONOMICS, *signed with the nom de plume Myrna Chase. In response to many requests, they are now being reprinted in revised and updated form. The complete current series, of which the present letter is the seventh, will be made available in a portfolio.*

By Anna Davis Hunt

The average mean value for the protein content of milk from representative healthy mothers* is generally placed at 1.5 per cent. In close approximation, the protein content of standard SIMILAC formula is 1.72 per cent.

Similac protein approximates breast milk protein in

ESSENTIAL AMINO ACID PATTERN AND CONTENT.



Similac, simulating human breast milk, provides all the essential amino acids in quantities necessary for maintenance needs as well as for a normal rate of growth. In addition, all the non-essential amino acids are present. (Not shown on graph.)

Similac protein is equivalent to breast milk protein in digestibility.

The curd of Similac (tension: zero) is as fine, as soft, as flaky as breast milk curd, thus assuring maximum surface area for enzyme action and rapid, unhampered digestion.

* For poorly-nourished mothers, protein values have averaged as low as 0.83 and 0.85 per cent.[2,3] The protein content of Similac is consistent and unvarying, always adequate — a fact to remember when breast feeding is not feasible.

1. *National Research Council: The Composition of Milks, Bull. 119, 1950.*
2. *Salmi, T.: Acta Paediatrica 31:1, 1944.*
3. *Spiess: Monatschr. f. Kinderhk. 97:242, 1949.*

Similac is available as Powder, 1 lb. tins, and Liquid, 13 fl. oz. tins.

the *brain*) or *colporrhagia* (*vaginal hemorrhage*).

For surgical terms, it's just as easy. Consider the various kidney operations:

Nephrectomy you'll find is *removal* (ectomy) of the *kidney* (nephr). *Nephrotomy* is an *incision* (otomy) into the *kidney*. *Nephrostomy* means *making an opening* (ostomy) into the *kidney*.

Cholecystectomy? That's merely *removal* of the *bile* (chole) *sac* (cyst); and the "bile sac" is, of course, the gall bladder.

I'm going to send you a copy of the "Textbook of Anatomy and Physiology." Study it thoroughly to learn the what and where of all these organs. Use it to gain a clear mental picture of the realm in which Dr. Barrie works. When you've finished with it as a textbook, keep it on hand as a reference work.

In taking dictation or even in casual conversation with the doctor, be on the alert for any unfamiliar word. Always ask him to spell it. He'll be glad to cooperate.

Then look up the word in the medical dictionary. Dissect it and learn by heart its meaning and spelling.

When I first started to take medical dictation, I got an indexed notebook. In it I listed my own shorthand symbols for the common prefixes and suffixes and for the terms most frequently used in our office. Since then the Gregg shorthand people have published a book of medical symbols. You might buy it to help you. Or you can make up your own symbols to suit Dr. Barrie's vocabulary.

At any rate, I'm sure it won't be long before words like *osteomyelitis* and *ovariorrhexis* will be flowing off your pencil point as quickly as you'd write *scat*.

Yours as ever,
Myrna Chase

Billed Up

• He was a good patient of mine, and I'd delivered all his children. So I was somewhat puzzled when his final payment for the last delivery failed to come in. Eventually it did arrive—along with a letter explaining the delay. Here it is, verbatim:

"To a great extent you have been the victim of my superstition. Twice in the past I've noticed that immediately upon final payment for your services, my wife would become pregnant again. That's why, this time, I stretched out my payments so long."

—BENJAMIN LEAVITT, M.D.

Common Parts of Medical Words

Roots

Aden	gland
Bio	life
Cardi	heart
Cephal	head
Cheil	lip
Chole	bile
Chondr	cartilage
Colp	vagina
Copr	feces
Cost	rib
Crani	skull
Cyst	sac
Cyt	cell
Derm	skin
Encephal	brain
Enter	intestine
Galact	milk
Gastr	stomach
Gynec	woman
Hem or hemat	blood
Hyster	uterus
Kerat	cornea
Leuc	white
Mer	part
Metr	uterus
My	muscle
Myc	fungi
Neph	kidney
Odont	tooth
Omo	shoulder
Oophor	ovary
Ophthalm	eye
Oss or oste	bone
Ot	ear
Ovar	ovary
Path	disease
Ped	children
Ped	feet
Pneum	lung
Polio	gray
Proct	anus
Psych	mind
Py	pus
Pyel	pelvis
Rach	spine
Rhin	nose
Salping	tube
Sapr	rot
Septic	poison
Tox	poison
Trache	trachea
Zoo	animal

Prefixes

A- or An-	absence of
A- or Ab-	from, away
Ad-	to, toward, near
Ambi-	both
Ante-	before
Anti-	against
Auto-	self
Bi-	two
Brady-	slow
Circum-	around
Contra-	against, opposed
Counter-	against
Di-	two
Dis-	the opposite of
Dys-	difficult, painful

Ecto-	outside
En-	in
End-	within
Epi-	on, upon
Erythro-	red
Eu-	well
Ex- or E-	from, without
Exo-	outside
Extra-	outside
Glyco-	sugar
Hemi-	half
Hetero-	other
Homo-	same
Hyper-	above, excessive
Hypo-	below, deficient
In-	in
In-	not
Infra-	below
Inter-	between
Intra-	within
Macro-	large
Meg- or Mega-	great
Mesa-	middle
Met-, Meta-	over, beyond, change
Micro-	small
Mycet-	fungus
Olig-	little
Para-	faulty, related to
Per-	throughout
Peri-	around
Poly-	many
Post-	after
Pre-	before
Pro-	before
Pseud-	false
Retro-	backward
Semi-	half
Sub-	under
Super-	above
Supra-	above, upon
Sym- or Syn-	with, together
Tachy-	fast
Trans-	across
Tri-	three
Uni-	one

Suffixes

-algia	pain
-asis	condition, state
-asthenia	weakness
-cele	tumor, hernia
-clysis	injection
-coccus	bacterium
-cyte	cell
-ectasis	dilation
-ectomy	excision
-emia	blood
-esthesia	feeling, sensation
-genic	causing
-iatrics	healing
-itis	inflammation
-logy	science of
-lysis	reduction
-oma	tumor
-osis	condition, state
-ostomy	forming an opening
-otomy	cutting into
-pathy	disease
-penia	insufficiency
-pexy	fixation
-phagia	eating
-phasia	speech
-phobia	fear
-plasty	molding
-pnea	breathing
-ptosis	falling
-rhythmia	rhythm
-rrhagia	excessive discharge
-rrhaphy	suture of
-rrhea	discharge
-rrhexis	rupture
-sthenia	vigor
-taxia	order
-ulation	act of
-uria	urine

...salts at sunrise...

"I clean the poisons out every day," he says—but he doesn't realize he is whipping a tired, irritated bowel.

Put this character on a treatment of Turicum. Explain to him it is not a one-shot cathartic but a restorative treatment that should be kept up for several days to help the bowel back to normal reflex peristalsis.

TURICUM®

lubricoid action without oil

It is pleasant and easy to take.

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CHICAGO 11, ILLINOIS

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'When Doctors Are Patients'

[*Continued from* 74]

in the morning to midnight, and I enjoy life perhaps more acutely now than ever before."

Of course, it's not enough merely to tell someone he must "learn to live with his disease," cautions Ian Stevenson. The patient must be *helped* toward a new attitude. Stevenson's grave illness made him keenly aware of the sick man's emotional troubles. Such a man furiously resents pity, for instance. "It is, after all, for understanding rather than pity that the average patient seeks a doctor, yet this important talent is far harder to acquire than the facile half-virtue of sympathy; both the praise and the scorn of the public for the latter are well summarized in the phrase 'bedside manner.'"

Even if the doctor feels little optimism, he must understand that there is therapy in hope, Stevenson goes on. Without deceit, he should therefore always encourage a patient to hope for improvement. "The trade of quacks and charlatans is swelled by patients who have been told by orthodox physicians that they 'must learn to live with their diseases.'"

Believing with Stevenson that a patient must do more than vegetate, Merritt B. Low has refused to be downed by residual paralysis from poliomyelitis. He practices pediatrics from a wheelchair and hasn't missed a day in five years. He concedes that perhaps he's fortunate in having children for patients, since the wheelchair doesn't daunt them a whit. In fact, they attempt a little hitchhiking on it.

Dr. Low believes that getting down to the patient's level physically may have important advantages. "I think many patients are overawed simply by the physical presence of the doctor as he stands menacingly above them in the ordinary examination. I noticed when in bed [as a patient] a feeling of greater ease if a visitor, professional or otherwise, sat down when possible, instead of standing practically on top of me."

Evasive Consultants

"I noticed, when in bed . . . " Those words, or variants of them, keep turning up in this book. When Dr. Henry Sigerist consulted some specialists, he "noticed" that most of them were secretive and evasive when asked direct questions. As a result, he gave up consulting other doctors.

Hospitalized several years later, he continued to notice things with a very observant eye. As a result, he expresses a profound hope to die at home. "I have a horror of the hospital, that blend of penitentiary and third-class hotel . . . It is a dreary

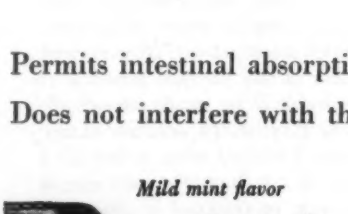
Carmethose® *liquid* controls antibiotic nausea

Permits intestinal absorption of the antibiotic

Does not interfere with therapeutic blood levels

Mild mint flavor

Exceptionally palatable



15 minutes before each oral dose of antibiotic

Clinical studies at Michael Reese Hospital, Chicago, and at the Mayo Clinic proved CARMETHOSE Liquid to be notably successful in suppressing "g-i" upsets from oral antibiotics.[1,2]

In comparative tests, CARMETHOSE had no significant effect on antibiotic blood levels, but aluminum hydroxide gel prevented adequate absorption of the antibiotic.

CARMETHOSE has no side-effects[3] . . . safe for routine use with oral antibiotics

CARMETHOSE Liquid is a 5% solution of sodium carboxymethylcellulose—a true buffer. Bottles of 12 fl. oz.

1. Greenspan, R., MacLean, H., Milzer, A., and Necheles, H.: Am. J. Dig. Dis. 18:35, 1951. 2. Parsons, W. B., Jr., and Wellman, W. E.: Proc. Mayo Clinic 26:260, 1951. 3. Necheles, H., Kroll, H., Bralow, S. P., and Spellberg, M. A.: Am. J. Dig. Dis. 18:1, 1951.

Ciba

place . . . with its sterile-looking rooms, bare walls, high beds, and the necessary but rigid routine that makes it so difficult to rest . . . Even the flowers that friends send us rarely succeed in brightening the room, [but] . . . rather give it the appearance of a funeral parlor."

Why Ugly Bedpans?

Julius Gottlieb, also on the subject of hospitals, makes a wry observation: "I must appeal to American inventiveness to displace the present models of the lowly bedpan. These awkward and uncomfortable contraptions occupy a high place in the practice of medicine . . . Yet how neglected! . . . They are carelessly hammered into ugly and discomforting forms, adding to the misery of the patient."

The bedpan played a vital role in Merritt Low's drama. Long immobilized by polio, he developed the granddaddy of all blocks. Now, he says, he knows why "sick people become focused on their gastrointestinal tract beyond all reason and common sense, while physicians often neglect [it] beyond all reason and sense. No one gave me the slightest real help on such a lowly thing as the functioning of my bowels. [It became] a major problem which took weeks of enemas, various laxatives, and thoughtful planning to unravel . . . The mathematically minded may be interested to know that I consumed over 600 grains of seconal, over 1½ quarts of cascara and over 1 gallon of milk of magnesia in a nine-month period."

Another bane of the hospital is the visiting Job's comforter. All patients have them; but when Fredric Wertham was under treatment for phlebitis he encountered some real dillies—his own colleagues in medicine. Here are some of their cheerful comments as Dr. Wertham recalls them:

"It's very common. It's nothing to worry about. I've seen hundreds of these cases at autopsy."

"Of course the edema often becomes chronic. But then it gets better with a spinal block. I had a case just like this where the edema lasted fifteen years."

"Usually these cases get better. Of course there's always a percentage that become chronic."

"In the beginning we doubted your ultimate recovery. But now we think you really have a chance to pull through."

Passages like these add a light touch to an otherwise serious and instructive book. But no random sampling can convey the true flavor of "When Doctors are Patients." If I've given you the impression that it's a bit preachy, then I've erred badly.

There's very little preaching in it, very little pedantry—but a great deal of humanity. In sum, it might be described as a book of fascinating true stories written especially for the physician and deserving of a place on his bedside table. END

'Today Science Found A Cancer Cure'

[*Continued from* 83]

Dr. Ivy and he presided. It was graced by the presence of a newcomer to scientific circles: State's Attorney Boyle.

Also there were a score or two of persons interested in cancer research. Several of them were surgeons, a few of them were clinical investigators themselves, but more were program administrators. There were assorted press and radio representatives; plus two or three unwanted business promoters; plus five women cancer patients, who were among the fourteen survivors of the first twenty-two treated with Krebiozen.

The conference was unprecedented in scientific research as a means of reporting a scientific discovery. It wasn't simply that this was chemotherapy and that one might suppose its mode of action would first be presented before a group of biochemists working in cancer. A brochure was handed out—"Krebiozen: An Agent for the Treatment of Malignant Tumors. Discovered by Stevan Durovic, M.D. Presentation by A. C. Ivy, Ph.D., M.D., Head of the Department of Clinical Science, University of Illinois."

This document by-passed biochemistry and was astonishingly free of anything but superficial clinical data. It constituted a clear break with custom—the scientist's custom of relying on the meetings of his scientific organizations and his journals for the dissemination of information. The Drake meeting seemed, in fact, to find closer parallel in the grand-opening ceremonies for such commercial products as automobiles and cake mixes.

While no press agent could have dreamed up a finer publicity stunt, the results of the meeting were unfortunate. From all over the United States and as far away as Brazil, cancer victims and their friends and relatives telephoned, telegraphed, and wrote to Dr. Ivy and to the University of Illinois, asking for Krebiozen.

Appeals addressed to the University exceeded 1,600 in one week alone. And in the nine weeks following, its office of public information said phone calls about Krebiozen had reached a total of 11,000.

The most spectacular—and, from the lay view, a most natural—example of public response came a week after the Drake announcement, when a Wilmington, Del., metalworker set a jet-propelled mercy flight in motion in behalf of a Wilmington woman dying of cancer. In a chance meeting, an Episcopal minister remarked to a friend that he had just been to the hospital to administer last rites to a woman dying of cancer. The worker overheard the

conversation and remarked, "Why didn't the doctor use that drug?"

He told of what he had read about Krebiozen in the newspaper. The priest said he would ask the woman's physician. The latter said the drug was not available. He was persuaded to make an effort, by telephone, to get it from Chicago.

As a result, a jet fighter pilot was found who would make a flight to Chicago. On landing, he said, "I'm after Krebiozen." He was handed some ampules of the drug, and he took off again. Finally, with siren accompaniment, Delaware state police rushed the serum to the dying patient. Her condition later was reportedly unchanged.

'Don't Come to Chicago'

In an effort to head off all comers, the University of Illinois then issued a series of form letters to be sent to patients and physicians. It publicly begged cancer victims: "Do not come to Chicago."

Everybody seemed to want Krebiozen except the medical profession, which six months later not only countered Dr. Ivy's claims with a 100-case study published in the Journal A.M.A. (Oct. 27, 1951), but disciplined him with a ninety-day suspension from the Chicago Medical Society for "unethical conduct . . . in promoting a secret drug." Said the Committee on Research of the A.M.A. Council on Pharmacy and Chemistry:

"Ivy and his associates have reported beneficial effects in a large majority of patients with cancer

it's the *healing* influence

of **cod liver oil**

that makes the great difference in

DESITIN®

hemorrhoidal

SUPPOSITORIES

the hemorrhoidal patient may sit, move and walk in greater comfort as Desitin Hemorrhoidal Suppositories with Cod Liver Oil act promptly to...

- **relieve pain and itching**
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Prescribe Desitin Hemorrhoidal Suppositories in hemorrhoids (non-surgical), pruritus ani, uncomplicated cryptitis, papillitis, and proctitis.

Composition: crude Norwegian cod liver oil, lanolin, zinc oxide, bismuth subgallate, balsam peru, cocoa butter base. No narcotic or anesthetic drugs to mask rectal disease. Boxes of 12 foil-wrapped suppositories.

Send for **samples**

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treated with 'Krebiozen.' The experience of seven investigators . . . does not agree with this conclusion."

The committee then added:

"The public may wonder at the wide divergence of opinion between the original report and these published results. Possibly a review of the pitfalls to be avoided in the clinical investigation of a cancer remedy may disclose how these discrepancies might occur . . . To those familiar with the long-term care of cancer patients, the unreliability of subjective response is notorious. Pain relief, appetite, ambulation, and speech are all affected by the subjective response of the patient to therapy, and therefore should not be relied upon as evidence of therapeutic efficacy . . .

"The investigator too must know the natural course of untreated cancer in order not to be misled by fluctuations in the condition of the patient . . ."

Can it be supposed that Physiologist Ivy was not aware of these factors?

Whatever the answer, the New England Journal of Medicine published an editorial in September, 1951, entitled "Strip-Tease Therapeusis," in which it commented: "The cancer cures that are announced 'in the vestments of scientific orthodoxy' and fail to live up to the publicity that is accorded them may cause as many heartaches as the out-and-out frauds that are perpetrated on the public." The New England Journal did not refer to Krebiozen by name, but listed a number of golden promises that had wound up naked and discredited after preliminary excitement.

'Cancer Cure Flops'

For the public, the Chicago Daily Tribune summed up the situation in an editorial entitled "Another Cancer Cure Flops." Some excerpts:

"The announcement of the drug, based on some preliminary treatments, got undue publicity because Dr. Andrew C. Ivy . . . allowed himself to be connected with it. Dr. Ivy is a distinguished physiologist, whose integrity is unquestioned but whose discretion in this matter *has* been . . .

"There are perhaps a hundred substances being tested today in laboratories and hospitals in the hope that they will control cancer cells. Perhaps one of these research programs will be successful; the probabilities are against it. There is a fundamental difference between these programs, however, and the krebiozen experiments; none of the other researchers is keeping the nature of his treatment material a secret, as Dr. Durovic has done . . .

"Medically speaking, krebiozen is dead. It should be buried without ceremony."

Why did Ivy do it?

If the question were merely an expression of curiosity, it might be dropped. It cannot be dismissed so easily for at least three reasons. All

of these involve areas of responsibility that Andrew Ivy might well have considered before lending his name to Krebiozen:

1. The public announcement raised, without apparent justification, the hopes of cancer victims and their relatives.

2. Dr. Ivy's professional colleagues, invited to the Drake meeting, were used as a sounding board for the Krebiozen announcement.

3. Although the University of Illinois itself was not sponsoring Krebiozen, Dr. Ivy inescapably involved the university because he was an official of it.

It seems certain that Ivy did not sponsor Krebiozen to make money for himself. A more likely answer may lie in a long chain of events that add up to an error in judgment —an error that Dr. Ivy has not admitted at this writing. The Chicago Tribune, in an article by Clayton Kirkpatrick, described the setting of the stage for this error as follows:

"Dr. Stevan Durovic flew from Buenos Aires to Chicago in March, 1949. He carried with him 1,000 ampules of Krebiozen and a letter of credit on the Bank of London and South America for $190,000 which his brother Marko (a munitions manufacturer) had given him.

" 'I came to Chicago, the medical capital of the world, to ask for a test of my new drug,' he explained. 'I intended to take it to Dr. Andrew C. Ivy because I knew his reputation as one of the greatest medical scientists in the world.'

"Thru a curious sequence of

MEDICAL MOMENTS . . . *SELF-CURE*

"Fooled you again, didn't I, young fella? Been smoking cigars! Yessir! Drinking whiskey, too. Threw away those pills you gave me . . . hog-swill! Out-live you and . . ."

You probably have your share of local irritants that you've just got to tolerate. Like seekers of free advice, amateur medicos . . . and obstinate patients like the crusty customer pictured above.

But there are certain other irritations you *don't* have to put up with. One of them is *hospital hands;* hands that get tender and sore from frequent and energetic scrubbings. Not when it's so easy and so pleasant to keep them smooth and comfortable with Noxzema. It's delightfully soothing—helps heal the tiny cracks. And Noxzema is greaseless, too. No greasy mess on your hands.

Here's another good tip. Rub a little Noxzema on your feet some night when they're hot and tired after a hard day. See how cool and refreshing it feels, how much better *you* feel afterwards!

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Regular Noxzema Skin Cream is a modernization of Carron Oil, fortified by adding Camphor, Menthol, Oil of Cloves and less than ½% of Phenol in a greaseless, solidified emulsion. Its reaction is almost neutral—the pH value being 7.4.

If you haven't tried Noxzema Skin Cream, we will be happy to send you a generous complimentary jar. Just drop a card to Dept. W, Noxzema Chemical Co., Baltimore 11, Md.

events in which contradictions never have been reconciled, Dr. Durovic did not go first to Ivy . . .

"Instead, he went to Dr. J. Roscoe Miller, then dean of the Northwestern University College of Medicine and now president of the University. Instead of Krebiozen, he showed Dr. Miller a substance which he called Kositerin. He asked that it be tested for its effects upon high blood pressure . . .

"Dr. Miller and his staff experimented with Kositerin for a time and reported that their tests were inconclusive. Dr. Miller suggested that Dr. Ivy might be interested in further experiments, and he telephoned Dr. Ivy . . .

"It was in Dr. Ivy's office, said Dr. Durovic, that he first disclosed that he had a drug which showed promise of combating cancer. Dr. Ivy agreed to test the drug . . .

"Dr. Ivy said that in his first half hour of conversation with Dr. Durovic he became convinced that the Yugoslav physician was honest, sincere, and willing to work. Furthermore, he said, the theory behind Krebiozen—the theory that a biological regulator could be introduced to control the wild growth of cancer cells—was a new and promising idea in cancer research.

"Dr. Durovic declined to disclose how he manufactured Krebiozen. In spite of this refusal, Dr. Ivy agreed to test it after it was demonstrated to be nontoxic.

" 'It is unusual in medical research for doctors to experiment with secret drugs,' acknowledged

Dr. Ivy, 'but the promise of this one seemed to me more important than the method of manufacture. I decided to give it a trial . . .'"

Thus Ivy responded to the everlasting human hope for a cancer cure. But that he should have reached such a decision was shocking to orthodox colleagues. The biological scientist abhors secrecy, as nature abhors a vacuum. As he sees it, anyone who makes a scientific claim and seeks to keep the basis of that claim a secret is not playing the game of research according to its rules.

These require him to be honest with himself, in so far as human psychology permits, by testing, measuring, and proving his observations and then opening up his theory and his claims to the examination of his fellow scientists.

The critical question is, "Can the man's work be duplicated?" So he must toss up his ideas like clay pigeons, with hits and misses all duly reported in the scientific literature.

Some scientists may cling to unproved or disputed theories, but none is expected to hide his clay pigeons. Freedom of knowledge and human progress are at stake.

Dr. Durovic, however, would not reveal the chemical process for producing Krebiozen to Dr. Ivy. The latter, therefore, chose to play a new game, in which the investigator must do his trapshooting in the dark.

In an analysis of the charges made in the Chicago Medical Society's investigation of Krebiozen, Ivy presented the critical question involved and gave his answer:

Q. "Why should mysterious concoctions processed by strange visiting foreigners be investigated under sponsorship which lends prestige to the investigation?"

A. "No stone should be left unturned in the search for knowledge which may save lives. A medical scientist, obscure or prominent, should not allow personalities and other extraneous factors to stop him from seeking the truth and the means of ameliorating pain and prolonging lives."

Having rationalized his position in this way, Dr. Ivy thenceforth placed himself at the mercy of the most unmerciful of all forces, circumstance.

One circumstance was that in the course of the clinical trials of Krebiozen, beginning in 1949 and continuing through 1950, quite a number of persons—doctors, patients, friends, and relatives—became aware that a new drug was being used experimentally in several small Chicago hospitals. Rumors leaked out.

For example, a newspaper columnist printed the tip that the University of Illinois was working on something hot in the treatment of cancer. Reporters began to dig for the story. The manager of the university's public information office was honestly able to tell science writers he knew nothing about the rumors, because Ivy had told him nothing. It was not

a project of the University of Illinois, but of a group organized later as the Krebiozen Research Foundation, whose officers included Dr. Ivy and State's Attorney John S. Boyle, and which had offices in the Palmolive Building.

It was only after the society writers of two Chicago papers learned of Krebiozen through friends of a socially prominent person who was being treated with it that Ivy realized, as he later explained, "that some statement would have to be given to the press in the near future."

Another circumstance was that Dr. Durovic and his wealthy brother Marko, who had supported Krebiozen research out of pocket, were having visa trouble. Their temporary visitors' permits were about to expire, meaning they would be deported to South America. So State's Attorney Boyle introduced them to Senator Paul Douglas of Illinois.

Senator Douglas was asked to introduce a bill in Congress to admit the Durovics on permanent residents' permits, the argument being that as discoverers and developers of Krebiozen they were possible benefactors of mankind and should not be booted out. Senator Douglas, learning of Dr. Ivy's interest, agreed to introduce the bill, but warned that Congress would want a good reason for granting this extraordinary privilege.

It was these circumstances, then, as Dr. Ivy later explained, that "demanded that a meeting be held to

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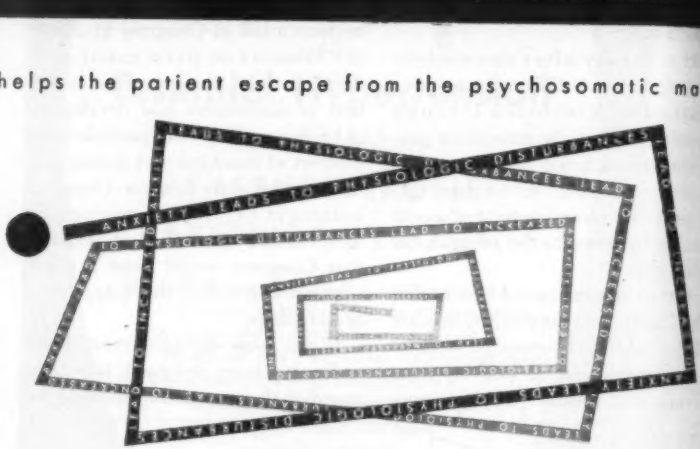
helps the patient escape from the psychosomatic maze



in anxiety states

SCHENLEY LABORATORIES, INC.,

plan a testing program and to make a conservative and accurate press release."

All the recognized science writers on Chicago newspapers were briefed on the situation and they agreed to cooperate in avoiding premature or exaggerated claims. The experienced science writer, unless frankly a sensationalist and tub thumper for one-day wonder drugs, does not want his readers to catch him biting into a lemon.

But a "public relations counsel"—whom, out of kindness, I shall not name here—had become well-informed about Krebiozen through Boyle. Without Ivy's authorization, this man whipped out an advance release on the Drake meeting calculated to make any huckster's spine tingle. His release began in part:

"The battle of medical science to find a cure for cancer achieved its realization today . . .

"A number of the patients who were cured of this dread disease were present and observed today at a meeting of leading cancer authorities and scientists interested in cancer research . . ."

That did it. The time-proved re-

Sound Track narration can now be added easily to medical films, thanks to this new 16 mm. projector. The sound is dubbed in on a magnetic strip along the edge of the film; it can be erased and re-recorded at any time. Thus the surgeon shown here, viewing films of his own operating technique, can record a narrative slanted for medical-society audiences. Then later on, if he wishes, he can dictate (right over the first recording) a new narrative angled, say, for medical students or nurses.

serve with which experienced science writers approach any "cancer cure" story was quickly broken down by a herd of sensation-seeking news and radio men. They had a field day. A good number of the seventy big names in medical science, who had been invited from far and near, were later able to congratulate themselves on their good sense in staying away.

Well known among his associates as a stubborn man, Dr. Ivy elected to stick by his guns, contending that he was not guilty of a breach of ethics, as the Chicago Medical Society said he was.

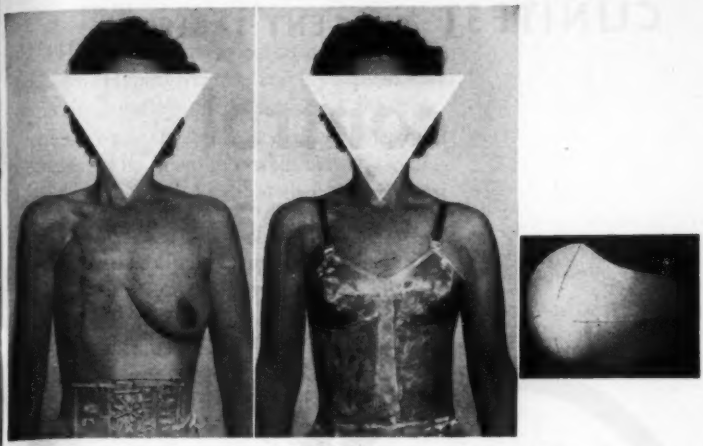
Dr. Ivy's Error

It is not the function of a science writer like myself to judge a scientist's ethics. One thing I have found is that the medical leaders with whom I have talked are unanimous: Ivy, in their opinion, was guilty of an error of judgment in sponsoring Krebiozen.

The Chicago Tribune quoted him as saying: "No editor would have accepted a report on a secret remedy. I have been the editor of medical journals myself. I would not have permitted a report on Krebiozen in any journal I edited."

And again, "I know it may cost me my reputation and my professional position, but I am determined to see this thru. I want to know the truth about Krebiozen, and so far it has not been completely disclosed."

That last is a fact. No one seems to have reported, at this writing, a



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Wherever support is indicated for breasts, back, abdomen—for women, men, children—you will find Spencer Supports demonstrably superior.

MAIL coupon at right—or PHONE a dealer in Spencer Supports (see "Spencer corsetiere," "Spencer Support Shop," or Classified Section) for information.

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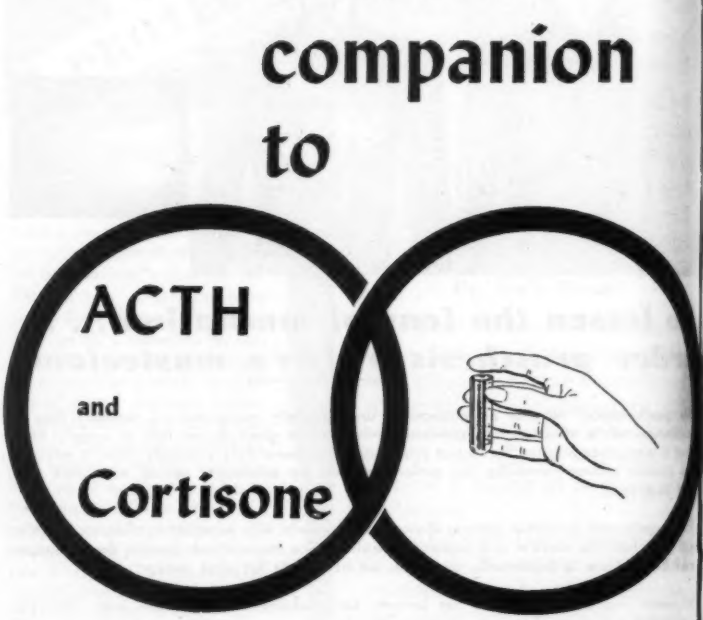

"In clinical practice it is clearly wise to test the urine of both diabetic and nondiabetic patients for sugar at intervals during administration of cortisone or ACTH and to carry out appropriate investigations and treatment if glycosuria occurs. Particular caution is necessary for diabetic patients."

Sprague, R. G.: Cortisone and ACTH, Am. J. Med. *10*:567, 1951.

ACTH and cortisone affect carbohydrate metabolism. Hyperglycemia and glycosuria may occur in nondiabetic patients and the treatment may unexpectedly reveal latent or mild diabetes. The insulin requirements of diabetics are increased so that their status must be followed with great care.

To avoid such clinical surprises and simplify clinical control, ACTH or cortisone therapy is profitably *preceded, accompanied* and *followed* by routine testing for urine-sugar with *Clinitest* Reagent Tablets. They provide a rapid, reliable and convenient method—easily used by both physician and patient.

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XUM

convincing story of Krebiozen's discovery and an evaluation of the background of its discoverer.

There is only one other point. We have seen what the hot-stuff techniques of irresponsible publicity can do to a man, whether he wishes to benefit from them or not. Yet as a result of the growth of fund-raising campaigns to support medical research, the research director and the scientific investigator are often under heavy pressure from the publicity man.

In some instances, scientists themselves must fill this role. Which leads inevitably to emphasis on "result research."

As one physician has observed, "It is a sad thing to contemplate that scientific institutions have to produce results in order to get money to support research to produce results."

This pressure for the funds to operate an enormously expensive scientific and educational plant obviously can shape a man's judgment. As the leader in research finds himself more and more at the mercy of public-relations morality, there will be more and more occasion to wonder whether, in terms of that tragic Broadway drama, we are witnessing "Death of a Salesman, Science Division." END

"No, sir. *Pedi-*, from the Greek *pais*, meaning 'child'—not *pedi-*, from the Latin *pes*, meaning 'foot.'"

(fat turn-over, liter

WYCHOL provides an important advance in lipotropic therapy: it combines choline with crystalline inositol.

The choline content of WYCHOL is more than twice that of most other choline preparations. The lipotropic activity of choline is enhanced by the action of inositol.

WYCHOL is offered for use in the prevention and treatment of excessive fat infiltration of the liver or vascular system and the sequels . . . cirrhosis, nephrosis, atherosclerosis, diabetes, hypothyroidism, etc.

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SUPPLIED:

Syrup WYCHOL, bottles of 1 pint.
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Supreme Court Quashes Kickback Case

[*Continued from* 89]

Split-fee deductions in about half our states. Twenty-three legislatures have enacted laws against fee splitting.* In these states, Revenue agents can be counted on to rule out split-fee deductions as "against public policy." It may take another court case to prove their right to do this; but in the meantime, *both* doctors who handle a split fee can expect to be taxed on it.

The exact wording of their state law will become more important to doctors. In some areas, split fees are illegal only if kept secret; in others, they're illegal under any circumstance. So the letter of the law will guide Revenue agents, even though this means different rules in different states.

2. *A slackening in the campaign against split-fee deductions in the remaining states.* Where there's no state law against fee splitting, such deductions may have to be allowed. Even so, expect a continued search for split-fee situations. The Revenue Bureau wants to be sure that at least one doctor (if not both) pays taxes on the money involved.

*For a complete list of states with anti-fee-splitting laws, see footnote on page 199, this issue.

Along with these two Revenue Bureau developments, expect a new drive for anti-fee-splitting laws in the states now lacking them. This was urged three years ago by the A.M.A. House of Delegates. Now that Revenue agents are prepared to lend effective support, many medical leaders see such laws as a good way to cut down ethical violations.

That's how the Supreme Court sees it, too. "We recognize the province of [state] legislatures to translate progressive standards of professional conduct into law," wrote Justice Burton, "and we note that legislation has been passed in recent years in North Carolina and other states outlawing the practice here considered. We recognize also the organized activities of the medical profession in dealing with the subject.

"The present trend," he concluded, "may lead to the complete abolition of the practice. If so, its abolition will have been accomplished largely by the direct action of those qualified to pass judgment on its justification."

In other words, it's better for medical societies and state legislatures to clean up local misdeeds than to have someone in Washington do it for them. That's unquestionably true. But in states that already have (or eventually get) laws against such misdeeds, the Commissioner of Internal Revenue now stands ready to lend a powerful hand in their enforcement. END

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There are two principal qualities which make VI-DAYLIN the ideal multivitamin supplement for children. They are:

1. HIGH POTENCY—The improved VI-DAYLIN formula now contains three times as much vitamin B_{12}, plus recommended daily allowances of six other essential vitamins. Sound therapy, indeed.

2. ACCEPTABILITY—Because VI-DAYLIN looks like yellow honey and tastes like lemon candy, children like it right out of the spoon.

Stable for as long as two years without refrigeration, VI-DAYLIN can be purchased in thrifty 1-pint bottles without fear of spoilage. Will not curdle milk; has no fishy odor; leaves no resistant stains. Available at pharmacies everywhere in 90-cc., 8-fluidounce and 1-pint bottles. Abbott

IMPROVED FORMULA

Each 5-cc. teaspoonful of VI-DAYLIN contains:

Vitamin A	3000 U.S.P. units
Vitamin D	800 U.S.P. units
Thiamine Hydrochloride	1.5 mg.
Riboflavin	1.2 mg.
Ascorbic Acid	40 mg.
Vitamin B_{12} Activity (by microbiological assay)	3 mcg.
Nicotinamide	10 mg.

'Now There's Dancing In the TB Wards'

[*Continued from* 82]

drugs? Is there any way to offset the damaging effects? These are questions of significance to all doctors.

Let's start with the news break of Feb. 21. Out of the welter of rumors and inferences, a clear outline of events isn't easy to make; but this is what seems to have occurred:

The story begins in Austria in 1912, when Chemists H. Meyer and J. Mally first synthesized isonicotinic acid hydrazide. No one gave its medical application a thought at the time, or for nearly four decades. Then, by a remarkable coincidence, the 40-year-old German formula was rediscovered almost simultaneously in the laboratories of Hoffmann-La Roche and Squibb.

Test tube and animal experiments gave striking results, and both pharmaceutical companies arranged last year for extensive tests on human beings. Dr. Elmer Sevringhaus of Hoffmann-La Roche made his arrangements with Drs. Irving J. Selikoff and Edward H. Robitzek of Sea View Hospital, a New York City municipal institution on Staten Island. Dr. Geoffrey Rake of Squibb made his with Drs. Walsh McDermott and Carl Muschenheim of New York-Cornell Medical Center. Other tests were made at Trudeau Sanitarium, Saranac Lake, N.Y.; and at Western Navajo Hospital, Tuba City, Ariz.

Although the first human application at Sea View Hospital was made on June 17, 1951, the secret of the drug was so well kept that not until the last week in December did Drs. Sevringhaus and McDermott learn, in conversation, of each other's projects. Then, on Jan. 8, 1952, doctors of both companies compared formulas. They agreed on an approach to the Food and Drug Administration. And they decided on what seemed to them the fairest way of announcing the drug.

The idea was to have first publication simultaneously, about April 1, in three scientific journals. At about the time of publication, a large formal meeting of doctors to discuss the subject would also be called.

'Inside Stuff'

The laboratories and hospitals involved had taken what they felt was every reasonable precaution to ward off premature disclosure. But on Feb. 15 Columnist Earl Wilson (tipped off by a friend of someone at Sea View) ran a small "inside stuff" item about a startling new development in tuberculosis treatment at a New York hospital.

Wilson's column is syndicated. So the rumor promptly took coast-to-coast flight. Wilson's own paper, the New York Post, reportedly put no

less than five leg-men to work on the story.

Pressure mounted swiftly. At last, New York's commissioner of hospitals, Dr. Marcus D. Kogel, felt compelled to invite publishers to confer with him. In the hope of establishing "a release date acceptable to all," he set the date for the conference as Feb. 25.

Meanwhile, though, a New York Times staff reporter named Arthur Gelb had also received a tip about the astonishing happenings at Sea View.

Calling a doctor friend there to check, he pricked up a surprised pair of ears at the answer: "Get off the line. My wire is probably being tapped. I'd be fired if it was learned I was talking to a reporter."

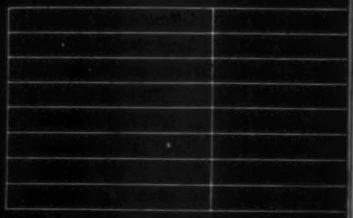
Gelb promptly began to dig in earnest. And the digging paid off when he finally cornered a medical man—unconnected with the project—who knew some of the facts and considered it a mistake to keep them secret.

With advice and help from William L. Laurence, the Times' science writer, Gelb filled out his story. It was checked and rechecked, its publication weighed from the public welfare angle, and finally, the afternoon of Feb. 20, given the go-ahead by Managing Editor Turner Catledge. It hit page 1 that night, about 10:30, in the early issue of Feb. 21.

The show was on.

By 11 P.M. the Associated Press and the New York Herald Tribune had phoned Dr. Kogel for confirma-

"magic"
in
a
syringe



tion of Gelb's story. Realizing at once that the cat was out of the bag, he verified the facts and called a press conference for the next day.

At first the story related pretty exclusively to a "municipally owned tuberculosis hospital." But press conferences of Dr. Kogel and the National Tuberculosis Association soon provided broader information. On Feb. 22, the names of both manufacturers and the hospitals involved were mentioned. On that date, too, the papers began to talk about 50-cent pills* available by spring, cures at a cost of $100 instead of $3,500, far more home treatment, and a possible great reduction of hospital beds needed for tuberculous cases.

On Feb. 23, warnings from a number of doctors appeared in the press, but most of the papers gave themselves over to describing the enthusiasm of patients. "Gaiety and dancing in the wards" (complete with pictures) had won a place, of a sort, in journalistic history.

From Sunday, Feb. 24, on, the over-all tone of stories became more reserved; and warnings against overconfidence were the order of the day. But these were buried in back pages. The front-page blaze of unexpected promise already had swept around the world.

Later it appeared that two other American firms, Schering and Nepera, had compounded the coincidence of discovery by starting experiments with the drug at about the same time as Squibb and Hoffmann-La Roche. Then came word from Spain that Bilbao's Laboratorio Faes also had discovered the drug (there called FSR-3), and that Spanish doctors had been trying it on human beings for three months longer than the men at Sea View, with much the same effect.

A Thousand Friends

That, then, is how one more medical discovery leaked out before its time.

The reasons for the premature disclosure are obvious enough. In the first place, as Dr. Kogel points out, tuberculosis has a dramatic quality that makes any story of a possible cure a prize to the news desk.

In the second place, a couple of hundred patients making spectacular recoveries from imminent death doubtless have a thousand relatives and friends who know and talk about the situation. In the third place, any project conducted in a tax-supported institution may be susceptible to the knowledge of politicians—and their reticence is not likely to equal that of scientists.

Actually, the consensus of men connected with the affair seems to be that there is a negligible chance nowadays of keeping any big scientific secret from the public. A strong demand for medical information has been built up among lay readers by innumerable popular books and ar-

*Predicted price a month later: 3 cents.

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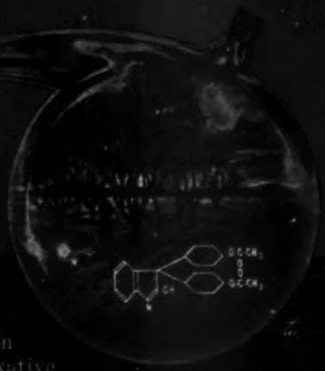

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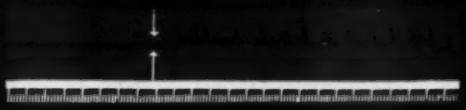
Now, A Harrower research team recently discovered that besides their emollient and colloidal properties, prunes contain an additional gentle peristaltic stimulant. This laxative principle is called ISATIN.



Kymograph tracing showing gentle increase in peristaltic waves produced by ISATIN.

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PRULOSE COMPLEX provides the essential gentle activation of peristalsis without any undesirable side effects.

PRULOSE COMPLEX is available in both tablet and the new liquid form.

DOSAGE 1 or 2 tablespoonfuls of liquid, or 3 or more tablets, with a full glass of water, twice daily, preferably after breakfast and before retiring, until normal elimination is established. The dosage may then be reduced.

SERVING THE PROFESSION IN A PROFESSIONAL MANNER

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ticles. When an exciting story comes along, some one is almost sure to tell it in headlines. The telling may cause enormous difficulties for doctors and heartache for patients—but there it is.

Some physicians not connected with the affair described here still feel that the TB-drug secret *could* have been kept longer and revealed at a later date in a more orderly, professional manner. Others point out that clinical investigation in a public hospital is necessarily harder to keep under wraps than research in a private institution. Still others maintain that information can be withheld from patients in either kind of hospital, and thus kept out of circulation (assuming, of course, that no doctors break faith).

While press relations are increasingly hard to handle in business, they're even more difficult in medicine. Scientists working on the development of new drugs can adopt either of two publicity policies. One is standard at Johns Hopkins, which keeps Baltimore newspapers informed of important experiments during their progress. Hopkins relies on the editors to hold their copy till the evidence justifies publication; at the same time it protects them with authentic information against the chance of an unforeseeable break elsewhere.

The second policy might be called that of the Sterilized Curtain—of trying to hide everything from lay journalists right up until publication in the medical press. Apparent-

ly this policy was applied to isonicotinic acid hydrazide. It clearly didn't work.

"The first Times story didn't even name the drug—or the men and hospitals and manufacturers involved," one doctor has said. "It was all a mystery—mystery drug, mystery circumstances, mystery results. That's a dangerous thing in a country like ours."

Admittedly, such omissions are unusual in a reputable newspaper; and they added to the general atmosphere of sensationalism. But the Times, in this case, couldn't help itself. For the facts had been withheld from its reporters—even from highly regarded science writers.

The Double Damage

At any rate, the Sterilized Curtain was swept rudely aside. At a conference called by the Medical Society of the County of New York, Dr. J. Maxwell Chamberlain of Bellevue Hospital later dramatized the resulting damage done to both patients and physicians. When seriously ill TB patients refused surgery in the hope of a quick, easy, pill-box cure, he said, they not only endangered their lives directly; they also upset long and carefully worked out schedules designed to effect their operations at the optimum time.

Typical of the plight of several communities was that experienced by Saranac Lake. This New York State town was planning added facilities for tuberculous patients even as the new-drug story broke. Since much of the story's emphasis was on

a small leak can sink a great ship

And a small bar of the wrong soap can defeat, or at least seriously hamper, the best therapy of a dermatologic condition. The use of an irritating detergent compound may further aggravate the affecting condition and greatly retard therapeutic response.

MAZON SOAP is prescribed by many physicians in the treatment of various skin conditions because it is a pure, mild, nonirritating detergent that gently cleanses the skin and prepares it for the antiseptic, antipruritic, antiparasitic action of MAZON.

For more than a quarter of a century, physicians have used this dual therapy in acute and chronic psoriasis, eczema, alopecia, ringworm, athlete's foot, and other skin conditions not caused by or associated with systemic or metabolic disturbances. MAZON is greaseless . . requires no bandaging; apply just enough to be rubbed in, leaving none on the skin.

MAZON

At all pharmacies

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A concentrated B Complex in a cola-flavored syrup

THIS IS THE FORMULA...

Each 30 cc. (1 fl. oz.) contains:

Thiamine Hydrochloride	36 mg.
Riboflavin	3 mg.
Niacinamide	180 mg.
Panthenol	6 mg.
(Equivalent to approx. 7 mg. calcium pantothenate)	
Pyridoxine Hydrochloride	6 mg.
Vitamin B_{12}	12 mcg.

—in a delightful cola-flavored syrup.

—Bottles of 8 fl. oz. and one pint.

Samples on request

help to medicine on just such oc
sions as this, he points out: Auth
tative spokesmen for medicine co
immediately go on the air whene
the spector of sensationalism aro

Where the new TB drug is co
cerned, the sensationalism has ari
not from the drug itself but fr
the publicity accorded it. The m
responsible for its development d
not claim that it gives the final a
swer to all the problems of tub
culosis. They did say that it h
proved itself spectacularly usefu
adding that disadvantages might y
appear.

Silver Lining

There is a feeling in some qu
ters that, in spite of everything, th
end result of the TB headlines m
not be all bad—that the promise
a really cheap and easy treatm
may bring thousands of previou
fearful cases into doctors' offices f
early diagnosis.

Again, while the story's breaki
ahead of plan caused confusion a
distress, it also helped close the g
between discovery and utilizatio
Under stress of public demand, t
Food and Drug Administration act
with unprecedented speed. The
regular announcement undoubted
contributed toward early F.D.A. r
lease of the hydrazide compoun
for general prescription.

Other modern drugs that we
publicized too early or too wide
created black markets or chang
hands in undercover diplomat
deals. There seems to be lit
chance of such effects in the pre

Ever since you were knee-high to a hop-toad, you've heard about America's wonderful *natural resources*—the bountiful fertile fields, the towering timber growth, the boundless water power, and the untold wealth of gold, iron, oil, silver, coal and other natural treasures that lie buried in the ground.

Is it because America has *more* natural resources than any other country that Americans enjoy the world's highest standard of living? No—many countries have as much—some have more.

Then is it because Americans *do* more with what they've got?

Yes! And the reason is as plain as the nose on your face. It's because Americans are free to develop their natural resources—and their natural resourcefulness—in the wholesome climate of *open and strenuous COMPETITION.*

COMPETITION—not "regimentation"—is what eggs a man on to do his best.

COMPETITION—not government control—is what urges a business to give its customers ever greater value for their money.

So let's say "NO SALE" to the *ism* peddlers who would have us swap our U. S. A. system of free competition for their "planned" regimentation—trade our U. S. A. freedom and plenty for their serfdom and poverty!

COMPETITIVE SYSTEM DELIVERS THE MOST TO THE GREATEST NUMBER

A new case history with pictures

The unique value of Dexamyl* in providing symptomatic relief from mental and emotional distress is clearly demonstrated in this case history—reported by a Philadelphia general practitioner.

Patient: S.M. (shown in photos on opposite page), "a lovely old lady", age 80, afflicted with arteriosclerosis, cardio-renal insufficiency, degenerative osteoarthritis and diabetes mellitus. She is "plagued with nervousness, profound weakness, vertigo, and pain."

"The only thing she asked of life was that she die before her children. Life did not grant her this balm. The untimely death of a daughter through suicide wrapped every one of her reflections in a package of misery."

Medical treatment: "Despite ... her cardiovascular pathology, I resorted to Dexamyl as the best of the geriatric armamentarium. At first she received two tablets on arising; one at noon; and one at 5 P.M. After two months I was able to reduce the dosage."

Results: "Dexamyl did not fail. It relieved her nervous uncertainty, her depressive weariness, her melancholia and her tearfulness. Dexamyl helped her to smile again."

Dexamyl

its "normalizing" effect

ameliorates mood . . . relieves inner tension

Each tablet contains Dexedrine* Sulfate (dextro-amphetamine sulfate, S.K.F.), 5 mg., Amobarbital, Lilly, ½ gr. (32 mg.) *T.M. Reg. U.S. Pat. Off.

Smith, Kline & French Laboratories, Philadelphia

These unposed photographs of patient S.M. were snapped during an actual interview with her physician. She is describing her symptoms of mental and emotional distress. See the opposite page for the case history of this patient.

ent instance. Manufacturers are well prepared on the production side and no legal obstacle exists to prevent other manufacturers from getting on the bandwagon.

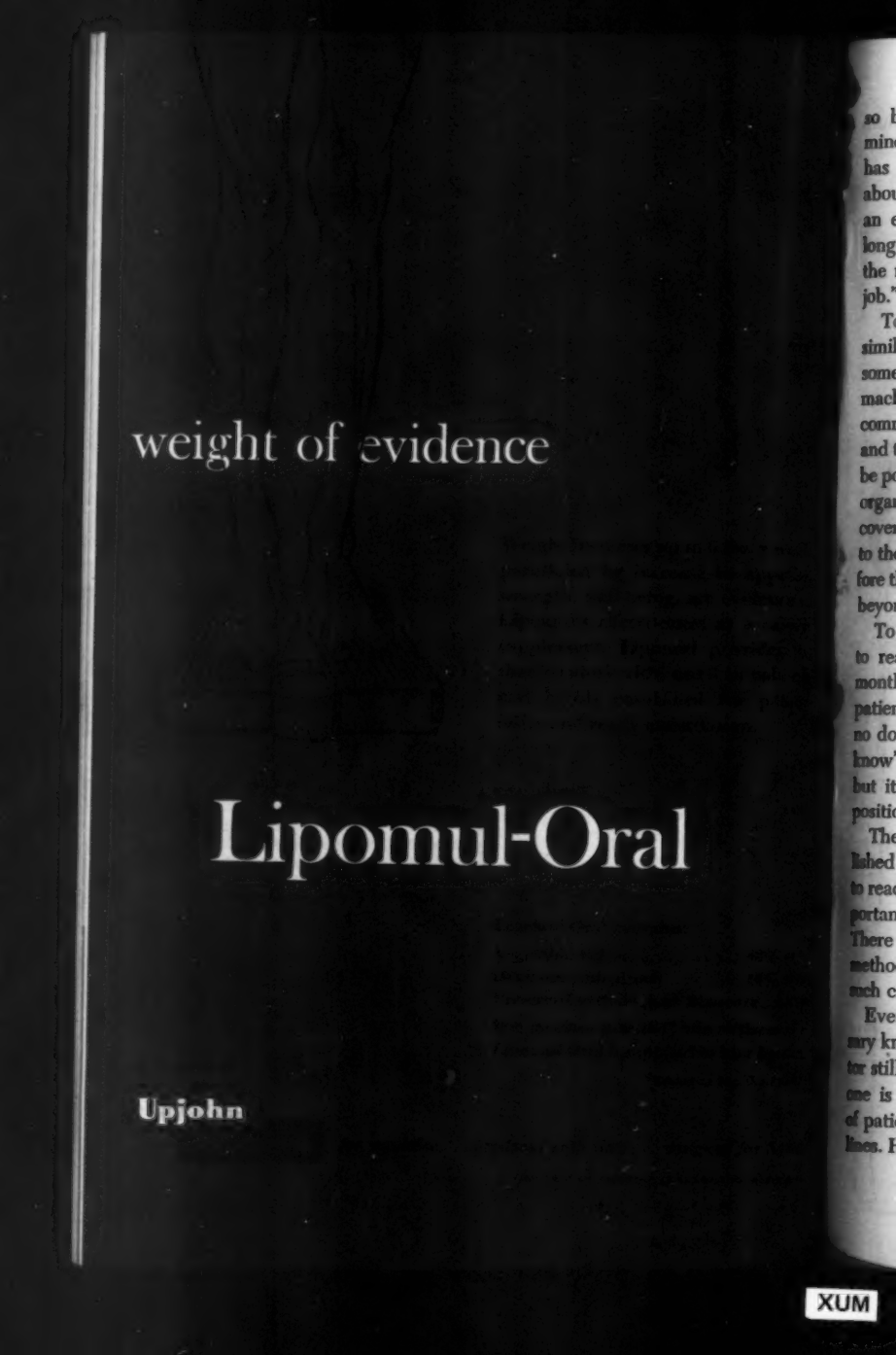
In fact, if no faults appear in future testing, a recent visitor from India may prove to have been right when he said of his 400 million compatriots: "It will be harder to watch them starve to death *without* tuberculosis."

Good for the Patient?

Cortisone, too, was pressured into earlier publicity than had been planned—though first publication in that case *did* occur in a scientific journal. Antabuse suffered from a too eager early press and was tested on 7,000 experimental cases before its F.D.A. release last fall. There was anguish and public clamor over much-publicized penicillin during the war, when supplies were monopolized by the armed forces. But Dr. Perrin Long, then of Johns Hopkins, admitted that the publicity hastened antibiotic advance by at least two years.

The increasing pressure for quick release of information about new discoveries is the result of many factors: competition among manufacturers; an understandable public demand for quick cures, intensified by development of such spectacular drugs as penicillin and the sulfas; a widespread lay interest in medical matters; a quite human affection for publicity; and a lively, uncensored press.

The anti-TB news "wasn't really


weight of evidence
Lipomul-Oral
Upjohn

so badly handled," one moderate-minded officer of a medical society has said. "I've heard doctors talk about it as if the world had come to an end, but I can't see any great long-term damage. You can't blame the newspapers—they just did their job."

To guard against their doing a similar "job" too often, however, some doctors are advocating that machinery be set up for improving communications between research and the practicing M.D. Wouldn't it be possible, they ask, to devise some organized method of evaluating discoveries and passing the news along to the whole medical profession before the public's temperature is raised beyond recall?

To the physician who had no time to read his morning paper a few months ago, excited questions from patients about "that new TB drug" no doubt came as a shock. "I don't know" was his only honest answer, but it left him in an embarrassing position.

There is already too much published material for any busy doctor to read in toto. But news of this importance demands his attention. There is a definite need for a reliable method of alerting all doctors in such cases.

Even equipped with the necessary knowledge, the individual doctor still has problems to solve. A big one is handling the over-optimism of patients who read only the headlines. He can't deny the whole story; neither can he go passively along with it.

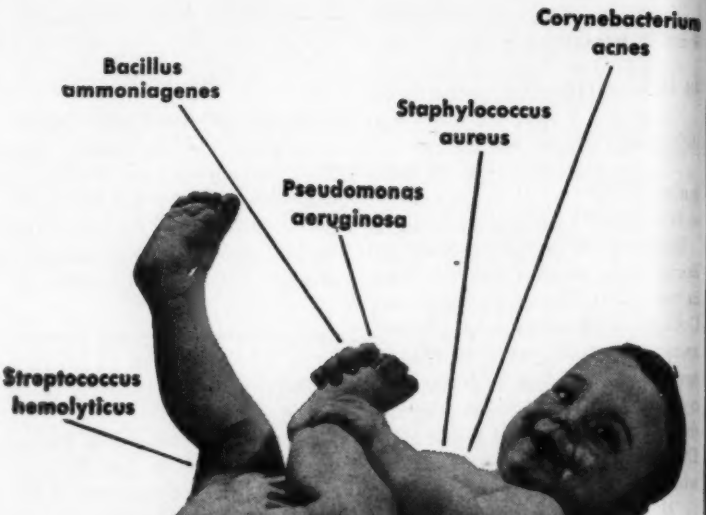
If his attitude toward all innovations is skeptical, he gets the reputation of being an old fogy. If he's too ready to try anything, patients may shy away from him as too much of an experimentalist. With claims of important therapeutic discoveries as common as they are today, the problem of how to handle them on the doctor-patient firing line becomes a real stumper.

The personality and experience of the individual doctor are crucial matters in such tests, as they are in so many others. But he will certainly welcome better public relations; faster and more reliable communication between research and the physican; and a vigorous, continuing effort to keep the public aware of solid medical opinion about new treatment methods. Only by such means will the burden on his tact be relieved, freeing him for more useful effort. END

HANDITIP

Car Cue

Keeping a tax record of car operating expenses is easy with a "Kar Diary" on your sun visor. A compact memo-roll gadget, it has spaces for noting each item bought, the amount, date, cost, and mileage—plus data on lubrication, repairs, etc.



In vitro and in vivo bacteriologic studies have confirmed the effectiveness of Johnson's Baby Lotion against a wide variety of potential pathogens associated with the common skin affections of infancy.

If you have not already done so, why not try Johnson's Baby Lotion? You will find this protective, soothing, pleasantly fragrant lotion a very helpful agent in the prophylaxis and treatment of *miliaria*, *excoriated buttocks*, *diaper rash*, *impetigo*, and *cradle cap*.

JOHNSON'S BABY LOTION

Johnson & Johnson

Fee Splitting: Why Is It Unethical?

[*Continued from* 70]

but mail them in the same envelope, as is sometimes done.

Such ethical pirouetting gives Dr. Bornemeier, among others, a pain in the office. "The A.M.A. and the College of Surgeons should throw away this 1913 code and write a new one," he said recently. In a communication sent to members of the board of regents of the college, Dr. Bornemeier gave his ideas on what the new code should contain.

"How simple, when the patient was ready to be discharged," he wrote, "for the surgeon to tell the family, 'The doctor and I have worked out this problem together. He has told you the fee is $500. That includes the services of both of us. You can pay either him or me.' Is that criminal? Is that 'buying and selling of people who are ill'? If it is not, then it should not be condemned."

Whether Dr. Bornemeier likes to think so or not, this *is* questionable (and in some states, criminal) practice. The procedure is ethically wrong because it leaves the division of the fee entirely up to the two doctors. And their valuation of the services each has contributed may easily be distorted by the fact that the referral has taken place.

In return for his lion's share of the $500, for example, the surgeon might take an unusually bright view —possibly without realizing it—of the general practitioner's pre- and postoperative ministrations, or of his assistance during surgery. When there's any difference between what the referring physician really *earns* as a physician and what he gets *paid*, that difference is a sales commission, and it has no place in medicine.

The ethical principle must be unyielding on this point. Medical services are hard enough to evaluate in terms of money without the added confusion of commissions.

What About Lawyers?

Some doctors who would rather change the ethics to conform to their practices than change their practices to conform to the ethics, seek to justify their position by means of an analogy. Referral commissions, they say, are accepted in full stride by lawyers; and lawyers are also supposed to belong to a profession with high ethical standards.

Actually, the analogy is less pat. It's true that when a lawyer refers a client to a law firm in another city, it's customary for the latter to remit a "forwarding fee" to the referring attorney. But most lawyers raise their eyebrows at similar splits following intracity referrals for specialized work, as in medicine.

Unless the referring lawyer has also worked on the case and bills

the client for his own services, the Canons of Ethics of the American Bar Association hold that the practice is unethical. Such splits are unquestionably commoner and less reprehensible, though, in law than in medicine. And the reason shouldn't be too hard for either lawyers or doctors to understand:

"The difference between industry and a profession is simple and unmistakable," the British economist Richard Tawney once wrote. "The essence of industry is that its only criterion is the financial return which it offers. The essence of a profession is that, though men enter it for a livelihood, the measure of their success is the service which they perform, not the gains which they amass."

By this standard, certainly, the practice of law must be considered nearer to the business standard than is the practice of medicine. When a lawyer sends a client to a specialist in corporate tax law, the entire transaction is concerned with money, and a money payment from the specialist to the referring lawyer is simply an appropriate detail of a business deal.

When a general practitioner sends a patient to a surgeon, the concern is not money but health and safety, and possibly life. Any money payment from the surgeon to the practitioner introduces an ugly suspicion that the commercial rather than the professional standard may have prevailed.

In twenty-three states,* the distinction is recognized by law; the medical practice acts of those states, in language of varying clarity, seek to prohibit fee splitting. Plainly, all these laws are aimed at taking business considerations out of professional referrals; in several states the law actually refers to the "buying and selling" of patients—without, however, defining this term.

In most states with anti-fee-spliting laws, though, the offense is described in fairly precise language. Identical laws in Michigan and Minnesota, for example, would revoke the license of, and possibly fine or imprison, "any physician who di-

*Alabama, Arizona, California, Colorado, Iowa, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Missouri, Nebraska, New York, Ohio, Oklahoma, Oregon, South Dakota, Tennessee, Texas, Virginia, Washington, West Virginia, and Wisconsin.

"By tomorrow, your wife will be herself again—I'm afraid."

clinically proved conception control

used without a diaphragm... applied with a measured-dose applicator...

Preceptin®

VAGINAL GEL

clinical report 634 patients

"In all, 14 failures occurred in 4046 woman-months exposure, giving a pregnancy rate of 4. This figure is substantially less than pregnancy rates reported from other series using jelly-alone, suppositories, and diaphragm-jelly combinations.

* * * * *

"It is easy to instruct the patient in the use of PRECEPTIN [vaginal gel], and because of this simplicity of use, more regularity and better results can be expected."†

clinical survey

summary of reports from 51 urban and rural areas

Analysis of clinical histories of 3270 patients who used PRECEPTIN vaginal gel under the direction of their physicians showed only 25 pregnancies — 99.2 per cent received complete protection. Incidence of irritation was only 0.6 per cent.

It is clear that PRECEPTIN vaginal gel's combination of simplicity and dependability makes possible its extremely high contraceptive effectiveness.

PRECEPTIN vaginal gel — a major advance in conception control developed by Ortho Research Laboratories.

composition: PRECEPTIN vaginal gel contains the active spermicidal agents p-Diisobutylphenoxypolyethoxyethanol and ricinoleic acid in a synthetic base buffered at pH 4.5.

bibliography: †Stromme, W. B., and Rothnem, M. S.: Clinical Experience with a New Gel-Alone Method of Contraception. World Population Problems and Birth Control, Annals of New York Academy of Sciences, Vol. 54, Art. 5, in press.

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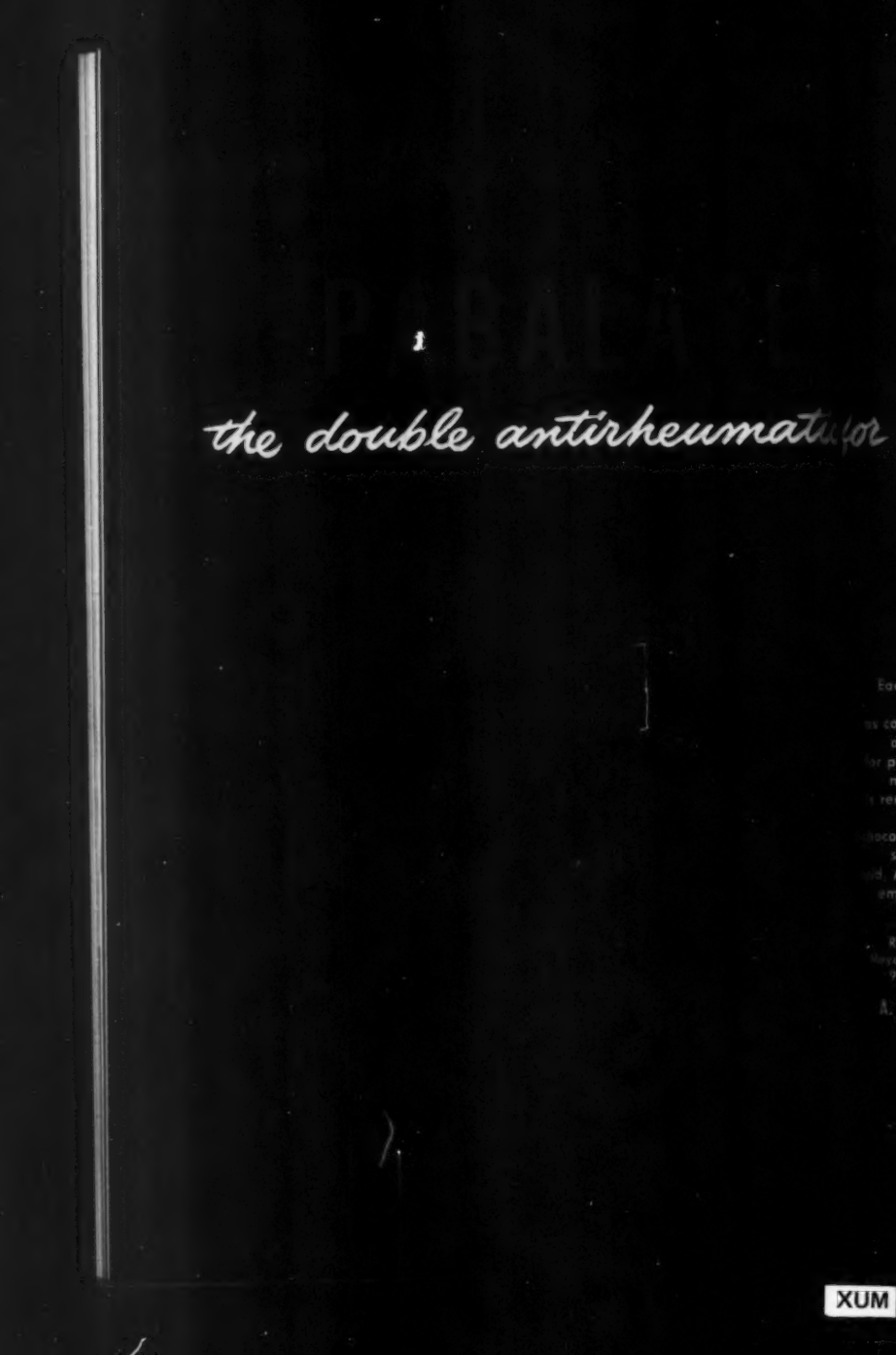
Manufacturers of Ortho-Gynol® vaginal jelly, Ortho-F Creme, Ortho® Kit, and Ortho® White Kit.


the double antirheumatic

vides a fee with or pays a commission to any person who calls him in consultation or sends patients to him; any physician who receives any such fee or commission."

In six of the states (Alabama, Iowa, Kansas, Kentucky, Tennessee, West Virginia), the law recognizes a nice ethical distinction: Knowledge and consent of the patient legalizes the division of a fee. At least from the legal standpoint, this solves the question of the joint bill for physicians in these areas: The bill is legal if it is itemized and illegal if it isn't.

Legal Penalties

In all but one of the twenty-three states with laws against fee splitting, a first or second conviction may cost the physician his license to practice. Other penalties include fines of from $25 to $1,000 and imprisonment of 30 days to a year.

Whatever the provisions of the laws, however, they are almost uniformly ineffective. The only person who is in a position to testify against a fee splitter is the person with whom he splits fees. And as a source of evidence, the latter is substantially less useful than the corpse in a murder case. Hence, prosecutions are rare and convictions rarer.

Unless the law gets help from the Bureau of Internal Revenue, which has threatened to disallow splits as business deductions on the physician's income tax return, it is not likely to prove any more effective than ethics as a means of eliminating fee splitting. END

Improved WELCH ALLYN No. 201 OTOSCOPE

permits easier diagnosis, treatment and instrumentation for GP or specialist

Because many doctors require a diagnostic-type otoscope which can also be used for treatment and instrumentation, we have made several modifications on our popular No. 201 Otoscope which adapt it for dual use. Because of the large diagnostic-type lens, this instrument is particularly well suited for physicians wearing bifocals.

The magnifying lens is now pivoted at the top on a spring-loaded pin which holds the lens in any position without slipping and will not loosen in use.

New thumb extension at bottom of lens frame makes manipulation of the lens quicker and easier.

New lower position of illuminating lamp gives greater area for visibility and instrumentation, without loss of light intensity.

Otoscope Head, with five nylon specula
$16.50
Fits all Welch Allyn battery handles.

Ask your Welch Allyn dealer to show you this improved otoscope

WELCH ALLYN, INC., Auburn, N. Y.

I Took an Alaskan Vacation

[*Continued from* 78]

Skagway), for example, it can't be more than 35 degrees at high noon in August. And it rains frequently, although generally in short bursts. So you need a raincoat, warm sport clothes, and a *warm* topcoat.

I learned all this the hard way. As a result, like Sam McGee in Robert Service's famous ba[illegible], I was "always cold."

Which brings me to my final suggestion: Read Robert Service. His poems didn't mean anything to me before this trip. I've read them all two or three times since I came back.

He catches the real flavor of the country—particularly in the stanza beginning: "There's a land where the mountains are nameless, and the rivers all run God knows where . . ." It ends:

There are valleys unpeopled
and still;
There's a land—oh, it beckons
and beckons,
And I want to go back—and I
will. END

"You can stop laughing now, Mr. Forbish. They're yours!"

a new concept

activated oral B_{12}

in high potency

Crystamin Forté CAPSULES

Each Crystamin Forté capsule contains:

*Crystamin . . . . . 100 mcg.
Desiccated Duodenum 75 mg.
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Supplied in bottles of 30.

NEW! Crystamin (crystalline vitamin B_{12} for injection) is supplied in 120 mcg. per cc. and 60 mcg. per cc. potencies in 5 cc. vials, and in 30 mcg. per cc. potency in 10 cc. vials.

MOST POTENT... MOST ECONOMICAL VITAMIN B_{12} CAPSULE AVAILABLE FOR THE TREATMENT OF ANEMIA

Formulated to meet the demand for high potency oral vitamin B_{12}. . . also contains folic acid and desiccated duodenum as activator[1,2,3,4] of vitamin B_{12}.

References: Meulengracht, E.: Acta. med. Scandinav. 85:79, 1935; (2) Bethell, F. H., et al.: Univ. Hosp. Bull., Ann Arbor 15:49, 1949; (3) Hall, B. E.: Brit. Med. J. 2:585, 1950; (4) Bethell, F. H., et al.: Ann. Int. Med. 35:518, 1951.

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-world-wide dependability

PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH

The Newsvane

Would Curb Hospitals' Firing of Doctors

The Medical Society of the County of New York has officially stated its belief that a doctor should not be dismissed from a hospital staff except for just cause. In a recently adopted resolution, the society recommends "an equitable system of tenure" for hospital staff members.

The society has asked the Hospital Council of Greater New York for approval of the resolution. Its most specific suggestion: A three-year probationary period, after which a staff man could be dismissed only for sufficient cause—such dismissal to be weighed by both the hospital's trustees and a review board representing the hospital and the medical society.

Mediation Offered in Insurance Disputes

Disputes between doctors and insurance companies may now be brought before an "insurance grievance committee" that has been set up jointly by the Hennepin County (Minn.) Medical Society and the underwriters. The committee—consisting of three physicians and three insurance men—will attempt mediation in the following types of cases:

¶ Disputes over fees;

¶ Alleged neglect on the part of M.D.'s to furnish reports on workmen's compensation cases;

¶ Charges of unethical behavior, which, if substantiated, will be turned over to the society for action;

¶ Alleged unwarranted interference by a company with matters that are properly under the physician's control.

The principals have agreed to be guided by the committee's decision.

Dubious Doctor-Druggist Deal Dealt Deathblow

Dr. R. F. Mills, a 45-year-old G.P. of Jacksonville, Fla., had a convenient arrangement with the Imperial Pharmacy, also of Jacksonville. He furnished it with a batch of signed prescription blanks; then, each time a customer wanted sulfathiazole or penicillin for self-treatment (sometimes of a venereal disease), the pharmacist on duty filled in a blank and collected $1 for it. Federal law called for a signed prescription, and there it was, so the customer's needs could be met easily. The $1 went into a piggy bank that eventually found its way to Dr. Mills.

But one day, not long ago, a self-

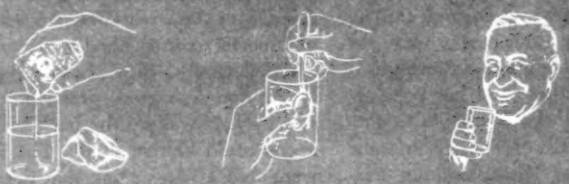
Peripheral Vascular Disease Treated with Specific Dynamic Action of Gelatine

Recent studies demonstrate that KNOX GELATINE offers a simple and economical method of producing continuing peripheral vasodilation with maintenance of total body heat. By directing KNOX GELATINE DRINK, your Raynaud-like cases or cases where vasodilation is indicated can be kept comfortable without resort to drug therapy or necessity of change of climate.

A brief discussion of the rationale of Knox Gelatine in vasodilation is on the facing page

HOW TO PREPARE KNOX GELATINE DRINK

Empty one envelope (¼ pkg.) Knox Gelatine in glass half-full of water, any fruit juice or milk, not too cold. Let liquid absorb gelatine; stir briskly and drink quickly. If it thickens, add more liquid and stir again. Food value 7 gms. available amino acid, 28 calories.... Since the specific dynamic action of gelatine lasts 2 to 3 hours, several envelopes of Knox Gelatine would be indicated throughout the day, as needed.



Available at Grocery Stores in 4-Envelope Family Size and 32-Envelope Economy Size Packages.

Abel[1] showed a marked increase in metabolic rate (**Specific Dynamic Action**) from the ingestion of a protein meal consisting mostly of gelatine. The effect was marked and sustained. Abramson and Fierst[2] had demonstrated a marked increase in peripheral blood flow from a protein but not from a carbohydrate meal, so that the increase could not have been due to the increase in oxygen consumption alone.

Recent scientific study[3] showed that the effective and sustained increase in peripheral blood flow is due to the high **Specific Dynamic Action** of proteins. Gubner et al[3] determined oxygen consumption; the skin temperature of the fingers, toes and forehead; the vascular oscillations of the calf and forearm muscles; and the blood flow of the hand and foot by a venous occlusion method,[4] before and after the ingestion of glycine. The increase in blood flow to the toes was fully equal to posterior tibial nerve block in the 6 cases in which comparison was made. This indicated maximal vasodilation, attained in 1½ to 3 hours after ingestion.

The **Specific Dynamic Action** of proteins is due to four amino acids, including glycine. Gelatine contains over 85 per cent of these amino acids. Following a protein meal high in gelatine, there occurs a peak in **Specific Dynamic Action** averaging 20 per cent of basal levels, and an increase in peripheral blood flow lasting over seven hours.[5]

1. Abel, M. S. The specific dynamic action of protein. Am. J. Med. Sci., 205:414,1943.
2. Abramson, D. I., and Fierst, S. M. Peripheral vascular responses in man during digestion. Am. J. Physiol., 133:686, 1941.
3. Gubner, R., DiPalma, J. R., and Moore, E. Specific dynamic action as a means of augmenting peripheral blood flow. Use of amino-acetic acid. Am. J. Med. Sci., 213:46, 1947.
4. Abramson, D. I. Vascular responses in the extremities of men. Chicago Univ. Press, 1944.
5. Lewis, T. Vascular disorders of the limbs. pg. 50, Macmillan, 1936.

You are invited to send for a new brochure on this subject. Write to Knox Gelatine, Johnstown, New York, Dept. ME

KNOX GELATINE U.S.P.

L PROTEIN—NO SUGAR

treating "patient" turned out to be an agent of the Food and Drug Administration. Net result: a $300 fine in Federal court for Dr. Mills, and a total of $700 in fines for Imperial's three pharmacists, who had also been trapped in the illegal sale of barbiturates.

Layman Still Lives After Attempted Self-Surgery

When Sidney Landry, 56, of Gretna, La., recently had a bad stomach ache, he decided to cure it fast. Thereupon, according to a United Press story, "he cut a gash in his abdomen and made his way to the kitchen sink. Taking out a segment of his large intestine, he washed it at the sink and put it back." Then, unable to close the incision, he telephoned a hospital.

Ambulance internes eventually succeeded in closing the wound. Rushed to the hospital, Landry was given a 50-50 chance to live.

Cites Hazard of Scanty Malpractice Coverage

You are courting disaster if you don't carry enough malpractice insurance, the Bronx County (N.Y.) Medical Society has warned. "What would you do if tomorrow you were handed a summons in a $150,000 suit *and* you carried malpractice insurance [only] to the tune of $5,000?" asks the society's bulletin.

It cites the example of a member who recently went through such an ordeal. His case was good and he

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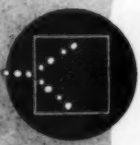
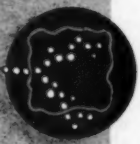
nonirritating passage

KONDREMUL® "plain"

COLLOIDAL EMULSION OF
MINERAL OIL AND
IRISH MOSS



permeates



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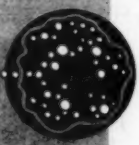

contributes bulk

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Irish moss concentrate—methylcellulose tablets. KONDRETABS* begin to liquefy in the stomach . . . do not gel until they reach the colon, where velvety, easily evacuated bulk is formed. Bottles of 50 and 100 flavored tablets.

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was represented by competent counsel. But he had only enough insurance to pay for legal costs and none to meet a judgment against him.

After an agonizing wait, the verdict was brought in—fortunately in his favor. Next day, says the bulletin, he increased his malpractice protection to $200,000.

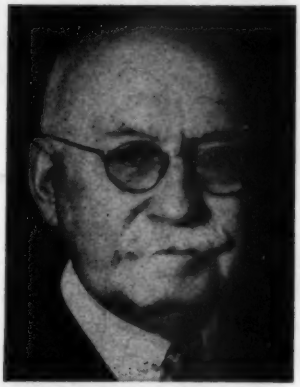
Few Lawbreakers Found Among Physicians

How many physicians run seriously afoul of the law each year? For a long time, the Federation of State Medical Boards has been urging its members to report such data. Last year, says Dr. Walter L. Bierring, secretary-treasurer of the federation, statistics were received from twenty-one states and the District of Columbia.

According to these figures, doctors aren't such a bad lot. In 1951, only fifty-four got themselves into real trouble. Thirty-three had their licenses revoked or suspended; twenty others were accused of narcotic violations; and one was charged with having performed an illegal operation.

Latest Role for British M.D.'s: Tax Collectors?

As one of their first economy moves, the British Conservatives decided to impose a tax on medical prescriptions and on certain appliances. Its purpose: to reduce costs of the National Health Service by encouraging patients to buy aspirin and other simple household remedies in drug stores rather than go to physicians for prescriptions.



Walter L. Bierring
Found: 54 troublemakers

To many British physicians, this seemed at first a noble idea. As the British Medical Journal put it, "there is a little doubt that some patients are importunate in their demands for medicine." Anything that might prevent abuses and reduce costs would be fine with it, the journal said.

But now that the prescription and appliance tax has gone into effect, many medical men have changed their tune. While a lot of them still approve of the tax in principle, they have two objections to the way it seems to be working out:

1. They're irritated at having to collect the prescription tax themselves. What's more, if they fail to collect the tax—a shilling for each prescription, more for appliances—they are obliged to pay the sum out of their own pockets.

2. The prescription tax, they say, imposes a burden on patients who most need the N.H.S. "free" benefits. Says the British Medical Journal: "It is illogical that a person with a long and serious illness should have to continue paying out shilling after shilling when the declared purpose of the scheme is to prevent abuse of the Health Service . . . It is not these patients who plague their doctor for that 'ceaseless cascade of medicine which is pouring down British throats' as Mr. Bevan once described it. Yet the scheme is a blunderbuss that hits them as surely as it does the tonic addicts."

Fearing that the impost on medicine may create a "financial barrier between doctor and patient," the medical journal asks the Minister of

HANDITIPS

▶ **What nontechnical procedure or device have you found helpful in conducting your practice more efficiently? MEDICAL ECONOMICS will pay $5-$10 for original ideas worth passing on to your colleagues. Address Handitip Editor, Medical Economics, Rutherford, N.J.**

Only on your Rx . . .

When prescribing Ergoapiol (Smith) with Savin for your gynecologic patients, you have the assurance that it can be obtained only on a written prescription, since this is the only manner in which this ethical preparation can be legally dispensed by the pharmacist. The dispensing of this uterine tonic, time-tested ERGOAPIOL (Smith) WITH SAVIN –only on your prescription–serves the best interests of physician and patient.

INDICATIONS: Amenorrhea, Dysmenorrhea, Menorrhagia, Metrorrhagia, and to aid involution of the postpartum uterus.

GENERAL DOSAGE: One to two capsules, three to four times daily – as indications warrant.

In ethical packages of 20 capsules each, bearing no directions.

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Literature Available to Physicians Only.

Ethical protective mark, M.H.S., visible only when capsule is cut in half at seam.

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Health to be more selective in imposing health charges.

"And," the journal repeats, "doctors should not be employed as collectors."

Forty Volunteer Doctors Honored by Mayor

The mayor of Cleveland recently honored forty medical specialists who had volunteered as consultants to the police department. He made them honorary members of the department and presented them with gold-plated badges.

The physicians will, without charge, treat policemen injured in line of duty and help decide on such matters as retirement and disability pensions and problems relating to civil defense. By expecting pay only if asked to perform operations, they will be saving the city between $10 and $40 a case.

The new board is said to be patterned after a similar one established in New York forty years ago.

Can Your Patient Tell a Cross From a Shield?

When the Blue Shield rejects a claim, the patient may become incensed at his physician. "It's the doctor's plan," he reasons. "The doctor handled my case and made the report. Didn't he know whether I was covered or not?"

Warning that this sort of confusion can seriously mar public relations, New York's United Medical Service advises physicians to find

Before Use of Riasol

After Use of Riasol

ARTHROPATHIC PSORIASIS

A therapeutic indication for RIASOL

The association of psoriasis with rheumatoid arthritis is so common as to suggest a related etiology. In some cases many believe the same metabolic disturbance may be responsible for both diseases.

Because RIASOL contains mercury chemically combined with soaps, in which form it reaches the deeper layers of the epidermis, it acts as an *alterative* upon local skin metabolism. This action explains in part why RIASOL cleared up or greatly improved the skin lesions of psoriasis in 76% of all cases treated in a controlled clinical group.

Saponaceous mercury, contained in RIASOL, penetrates the superficial layers of the epidermis and works directly upon the cutaneous lesions of psoriasis.

RIASOL contains 0.45% mercury chemically combined with soaps, 0.5% phenol and 0.75% cresol in a washable, non-staining, odorless vehicle.

Apply daily after a mild soap bath and thorough drying. A thin invisible, economical film suffices. No bandages required. After one week, adjust to patient's progress.

Ethically promoted RIASOL is supplied in 4 and 8 fld. oz. bottles, at pharmacies or direct.

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RIASOL FOR PSORIASIS

out what specific coverage each patient has. A layman, says U.M.S., may not understand the language of the benefit schedule, so it's up to the doctor to enlighten him.

U.M.S. reveals that nearly 80 per cent of its disallowed claims are rejected because of four typical misunderstandings:

¶ Medical care is reported, but only surgical care is covered by the patient's contract.

¶ The subscriber has failed to observe a specified waiting period before applying for benefits.

¶ Medical treatment in the home is reported, but coverage is limited to in-hospital care.

¶ The patient has Blue Cross coverage only, not Blue Shield.

Everyone Is Richer —Except the Rich

It's well known that the rich are getting poorer and the poor are getting richer. But how does this affect one's daily life? Is the current economic reshuffling making its mark, for example, on the physician's practice?

Medical men can draw their own conclusions from a recent report of the National Bureau of Economic Research on the distribution of the nation's income. In plotting a significant shift of income distribution during the twelve-year period from 1936 to 1948, the survey shows that the U.S. has gone a long way toward wiping out income inequities. It shows also that:

¶ Poverty is on the decline. The number of family units with sub-

in Others' Words

Philippine Physician:

"I have little wealth and am in no position to contribute to this Foundation today. But as every cent I own has been earned with so much honest toil it would give me real peace of mind to know that upon my death whatever I might leave will be utilized nobly and wisely. Would you have any objection to my making a will and naming the Foundation as my heir?"

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If you have missed doing your part—why not send your contribution today. All gifts can be earmarked for any one of the approved medical schools—and the money is income-tax deductible. Send your check now.

American Medical Education Foundation

535 North Dearborn Street, Chicago 10, Illinois

standard income ($1,000 or less) has dropped by two-thirds since 1939. And while three out of four families had "minimum" income ($2,000 or less) in 1939, only one out of three is below the $2,000 mark today.

¶ There are more well-to-do people now than ever before. The number of families in the $5,000-and-over income class has risen from one in fifty to one in six in the past dozen years or so. The number of families in the "high" income bracket ($10,000 or more) was only one in 100 during the Thirties; yet by 1948 it was one in twenty.

¶ The ranks of the wealthy are being steadily depleted. Thirty-five years ago, the top 1 per cent of the people received about 16 per cent of the national income. Now, the top 1 per cent gets less than 9 per cent of the national income.

Thus the average physician today has far more patients in the middle-income bracket than ever before. Which raises some interesting questions. For example:

Are patients better able to pay for medical care today than they were in the Thirties? Has the need for charity medical care diminished? Is a sliding scale of fees becoming less essential?

While the bureau's study does not pretend to answer any such questions, it does show that, with the exception of the people at the top of the income scale, nearly everyone is better off today than he was during the Thirties. Nor are the

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Babies Enjoy Better-Tasting Heinz Baby Foods!

Even The Tiny Tots In Your Care Will Appreciate Finer-Tasting Heinz Baby Foods! Heinz Retains Fresh Flavors And Colors—And A High Degree Of Vitamins And Minerals—By *Scientifically* Cooking Select Fruits And Vegetables From America's Finest Farms And Orchards!

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To Be Sure—Recommend

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gains merely paper ones; they "substantially" outweigh price rises.

Chances are that the rural physician will not share in the redistribution of wealth as much as his colleague in the city. Though the economists point out that the cost of living is much less in farm communities, they add that the problem of poverty is far greater in the country than in industrialized urban areas.

The causes of this redistribution of income are said to be these: the graduated income tax, the growth of progressive management and trade unionism, increased national production, wage controls, Federal agricultural subsidies, and social legislation.

The nation's medical men have also played a part in retouching the economic picture. One of the factors said to be responsible for the income shift is the growth of health services —presumably because better health has increased the earning power of the average U.S. citizen.

Senator Douglas Praises U.S. System of Medicine

The big flaw in the Ewing health plan is its grandiose attempt to cover all the ills of man, making it an almost "slavish" imitation of the British National Health Service. So says Senator Paul H. Douglas (D., Ill.).

"Virtually all people can bear the cost of transient illness," Senator Douglas declares. "What puts a family behind the eight-ball is a prolonged illness, a long stay in a hospital, a costly diagnosis, a succession of doctors."

Paul H. Douglas
No slavish imitation for him

Even families with incomes of $40 a week can meet medical costs of $100 or $150 a year, the Senator believes. It's only when prolonged or chronic illness strikes that the burden sometimes becomes insupportable. Therefore, Douglas goes on, the Ewing plan is wrong when it advocates protection against "the medical costs of the common cold" as well as against "the mysterious diseases which require . . . great expenditures of money.

"All the illustrations which Mr. Ewing and his supporters brought forth to defend their universal and all-inclusive system were drawn from the fields of chronic illness and

We could not exist without it . . .

Iodine is perhaps the most mysterious of the myriad substances in the sea. Since the moment iodine first became part of tissue chemistry, living things have become increasingly dependent upon it. *We ourselves cannot exist without iodine because it is an essential part of thyroxin, the hormone that regulates our metabolism.*

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A Demonstrably Superior Iodine Preparation For Internal Use

ORGANIDIN (Wampole), an exceptionally well tolerated iodine preparation for internal use, may be administered routinely to protect the patient from "the minor and major, overt and hidden, temporary and continuing effects on the human body and mind of insufficiency of iodine in the diet. . ." (N.Y. State Journal of Medicine, *49*:2770, 1949).

ORGANIDIN, standardized to provide 2.5 Gm. of iodine (organically combined with glycerin) per 100 cc., is entirely free of inorganic iodides and negative to starch test solution. Bottles of 30 cc. with dropper. *Samples and literature on request.*

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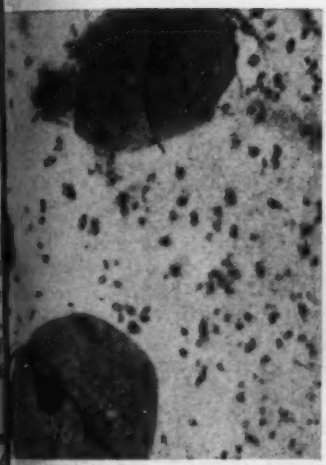

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A *Dorsey* PREPARATION

in trichomonal and other vaginal affections

Vagisol Suppositabs (suppositories tablet-shaped) provide the dual approach needed to combat effectively trichomonal and other vaginal affections.

1. Through the powerful antibacterial actions of tyrothricin and phenyl mercuric acetate many vaginal pathogens are destroyed rapidly.
2. By means of the combined actions of succinic acid, sodium lauryl sulfate, papain, and lactose, vaginal acidity is restored and drainage facilitated, thus encouraging the development of the normal vaginal inhabitant, the Doederlein bacillus.

Vagisol Suppositabs are indicated not only in parasitic and fungus vaginal infestations, but also in many vaginal and cervical infections. They are advantageously employed prior to local surgery.

Average course of treatment is one Suppositab inserted morning and night for a period of three weeks.

For insufflation in office practice, Vagisol Powder (1 Gm. equals 1 Suppositab) is available in packages of 45 Gm.

VAGISOL

SUPPOSITABS

Each Vagisol Suppositab provides:

Phenyl Mercuric Acetate	3.0 mg. (0.046 grain)
Tyrothricin, N.F.	0.5 mg. (0.008 grain)
Succinic Acid	12.5 mg. (0.193 grain)
Sodium Lauryl Sulfate	3.0 mg. (0.046 grain)
Papain	25.0 mg. (0.385 grain)
Lactose	q.s.

Supplied in bottles of 36.

SMITH-DORSEY

Lincoln, Nebraska

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catastrophic sickness," he says. "But the plan itself did not confine itself to the illustrations which were used in its support. It covered the waterfront."

Without minimizing "the very serious plight in which hundreds of thousands of Americans find themselves" as a result of unusual medical expenses, Senator Douglas maintains that the problem can and should be solved within the framework of our present system. One suggestion he offers is the development of a national insurance fund, or regional funds.

To the question, "Who would manage such a fund?" he replies: "I'm for any system that will work, that will provide protection. Like most Americans, I have a bias in favor of voluntary, non-governmental bodies. The American system of individual medicine can meet the ordinary events of life . . . and we do not need to pull the medical profession up by the roots in order to get an answer."

Cut Down on Useless Staff Meetings?

The staff secretary announced the approval requirements of the American College of Surgeons: monthly general staff meetings at which attendance is compulsory. Then he dutifully called the roll—recording, for future reference, the names of "the faithful."

How often have you begrudgingly sat in on a hospital staff meeting that began in this fashion? If you're like a good many U.S. physicians, your answer is "Too many times."

Indeed, the monthly general staff meeting has been a long-standing source of confusion and resentment in some A.C.S.-approved hospitals. The big question: Is the compulsory meeting-a-month policy really necessary?

Not long ago, Dr. Paul R. Hawley, A.C.S. director, came up with a hopeful answer. In acknowledging a complaint from one group of medical men, Dr. Hawley wrote: "The American College of Surgeons has not required and does not now require a specified number of general staff meetings . . . One general staff meeting every three months, or four each year, will meet the requirements of the College *provided* that the basic objectives of the approval program are attained in other ways."

Hailing the Hawley letter as a "welcome pronouncement long overdue," the journal Northwest Medicine accuses many hospitals of the "false assumption that mandatory attendance at staff meetings [assures] adequate information and education." After seeing doctors "asleep" and "inattentive," arriving late, and leaving early at innumerable meetings, it's impossible, adds the journal, "to hold any illusions that attendance at staff meetings and education are synonymous."

Northwest Medicine underscores

this quote from another Hawley letter: "Too many staff meetings are merely duplications of county medical society meetings." This statement, it points out, "confront[s] surgeons with the moral obligation of . . . assuming leadership in . . . the elimination of mandatory monthly staff meetings and the usual accompanying program which duplicates medical society activity."

"What," asks the journal, "are we waiting for?"

Chiropractor Seeks to Liquidate the A.M.A.

When Ruth B. Drown, a Hollywood, Cal., chiropractor, was dragged into court last November on the complaint of several medical organizations, she was hopping mad. The jury found her guilty of "mislabeling" a radiotherapeutic device, and a U.S. judge fined her $1,000.

Dr. Drown got even madder. Not one to let bygones be bygones, she has now appealed her case and filed some countercharges. The main objectives of her suit:

1. To collect $5 million in damages;

2. To wipe out the American Medical Association, the California Medical Association, eight other medical groups, the U.S. Pharmacopoeial Convention, and its 154 member corporations. (All these organizations were named as defendants in the legal action.)

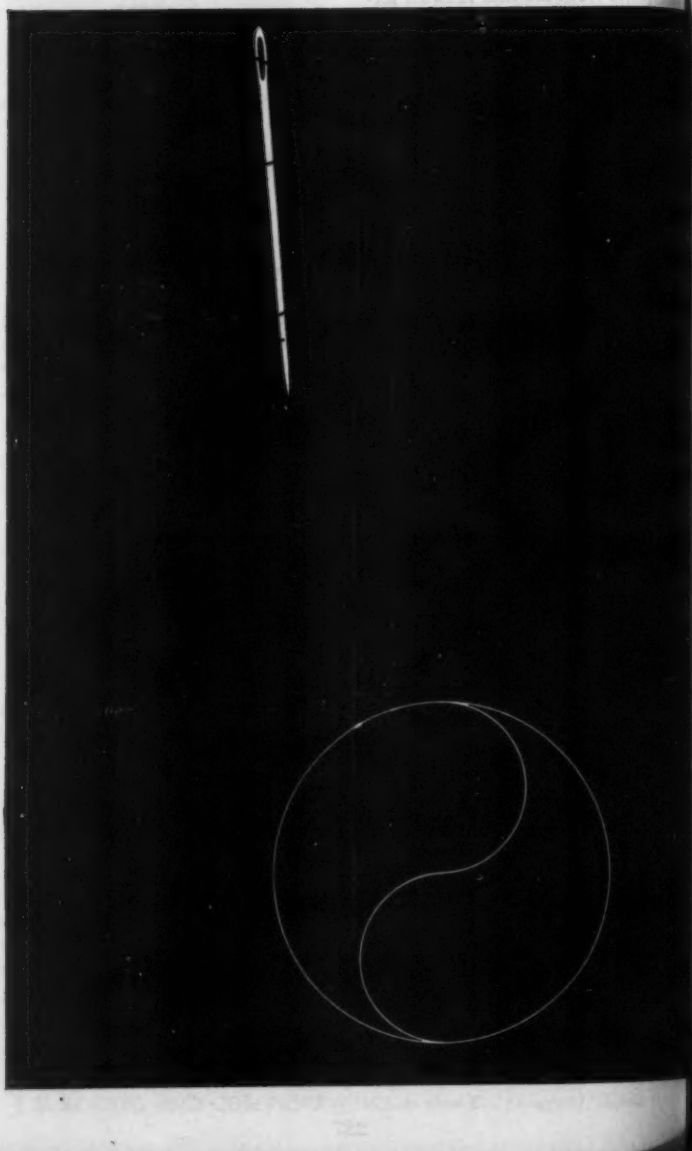
Her charges: that the several defendants plotted to "engineer" her prosecution under the Pure Food and Drug Act and attempted to create a monopoly in violation of Federal anti-trust laws.

Ruth B. Drown
Down with medicine!

Birth-to-Death Plan Wins Coast Unions

A good many people don't want just health insurance; they also want life, accident, and disability insurance. Still to be solved, by most Blue Shield plans, is the problem of how to give them all they want in a single package. One plan whose experience over the past couple of years seems to prove the problem a soluble one is the California Physicians' Service.

When C.P.S. officials became single-package minded, they went to



see the big commercial insurance companies. Soon the companies and C.P.S. were partners. The theory behind the partnership was simple: In the words of the health plan's director, W. M. Bowman, "We, as a doctors' organization, provide the medical, surgical, and hospital care; the life insurance companies . . . provide the life insurance, disability benefits, and unemployment compensation."

Already, the California Physicians' Service has parlayed this theory into a highly significant development in the field of health insurance. The multi-policy package insurance that C.P.S. and the private carriers are offering West Coast employe groups is, in the words of one labor leader, "the most comprehensive welfare plan available today."

Take, as an example, the C.P.S. insurance package adopted by locals of the Amalgamated Meat Cutters and Butcher Workmen of North America. This package includes seven separate policies. They provide hospital service, accident coverage, surgery, medical care, catastrophic coverage, life insurance ($5,000), and accidental death and dismemberment insurance ($5,000).

Premiums for this meat man's contract are paid by the employer. The worker, if he wishes, can buy the same protection for his spouse and all dependent children (@ $5.72 a month) or for one dependent only (@ $3.30 a month).

Though comprehensive plans of this type were designed mainly for bargain-hunting union and management negotiators, they have appealed also to many smaller industrial organizations that have no acute labor problems. Some groups include as few as twenty-five workers, with the employer paying all or part of the premium.

So far, about 1,000 organizations in California have entered into one-package insurance plans, and some 32,000 persons are covered (although not all of them get the maximum benefits of the butchers' union plan). The California Physicians' Service retains full control of selling and promoting the plan.

Unified Buying Cuts Down Military Medical Costs

Although military unification on a general scale met tooth-and-nail opposition from some service groups, it seems to be working out pretty well in the medical departments.

This is the opinion of Representative F. Edward Hebert, chairman of the House Armed Services subcommittee. He and his colleagues have been reviewing the work of the Armed Services Medical Procurement Agency, a cooperative buying unit for the Army, the Navy, and Air Force.

Their conclusion: The agency might well serve as a model for other branches of the armed forces.

Spokesmen for the agency say its cooperative buying has reduced by

40 per cent the number of medical items once required by U.S. military forces. When the three armed services were buying separately, 10,344 items were catalogued by military medical departments; under unified purchasing, only 6,100 items are listed. Result: "an annual saving to the U.S. taxpayer of millions of dollars."

Should a Doctor Get A Doctor Bill?

While a Los Angeles physician was shuffling through his mail one morning, he saw something that made him blink. It was an envelope that yielded, of all things, a doctor bill. The bill bore the imprint of a local psychiatrist who had treated one of the doctor's dependents.

Later, at his county medical society, the M.D. registered a mild complaint. "Isn't it unethical for a physician to charge for treating a local colleague or his dependents?" he asked.

For officers of the county society, it was a twice-told tale: In recent months they had received many similar complaints, most of them stemming from bills received by doctors for psychoanalysis. There had been enough squawks, in fact, to make some local medical men wonder whether psychiatrists are (or should be) exempt from the ethical rule of professional courtesy.

Asked by Dr. Louis J. Regan of the Los Angeles society for its advice, the Judicial Council of the A.M.A. has come up with an answer to this ethical poser:

Louis J. Regan

Professional courtesy for all

"A physician may not ethically charge a professional fee for services rendered to a [colleague or] a colleague's dependents in the local community. Although it does not seem necessary, it is nevertheless pointed out that these principles apply to psychiatrists in like manner."

But, the A.M.A. council adds, in the case of psychoanalysis or other extended treatment, some adjustment may be necessary. When a physician (psychiatrist or otherwise) has performed an "unusual service"—say, twice-weekly treatments for several months—he should be compensated, the council says. In such cases, it points out, it is usually not proper for a physician to

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NOW...*effective, comfortable, sustained relief* from pain, cramps, general discomfort due to functional gastrointestinal spasm. In clinical studies,[1, 2, 3] BENTYL gave gratifying to complete relief in 308 of 338 cases, yet was "... virtually free from undesirable side effects."[3]

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SAFE, DOUBLE-SPASMOLYSIS

Each capsule or teaspoonful syrup contains:

BENTYL . . . . . **10 mg.**
For comfortable relief of nervous indigestion

BENTYL . . . . . **10 mg.**
with **PHENOBARBITAL** . . . . . **15 mg.**
When synergistic sedation is desired

DOSAGE

ADULTS: 2 capsules or 2 teaspoonfuls syrup 3 times daily, before or after meals. If necessary, repeat dose at bedtime.

IN INFANT COLIC: ½ to 1 teaspoonful syrup 3 times daily before feeding.[4]

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...W.: J. Med. Assn. Ga. 40:22, 1951. 2. Hufford, A. R.: J. Mich. St. Med. Soc. 49:1308, 1950. 3. Chamberlin, D. T.: Gastro-...17:224, 1951. 4. Pakula, S. F.: Postgrad. Med. 11:123, 1952.

Trade-mark "Bentyl" Hydrochloride

…bmit a bill to a local colleague; …er it's up to the physician who …ided the professional service to … the initiative.

…or the record, the A.M.A. coun… notes two other exceptions to this …ical rule of thumb:

¶ The physician providing the …tment may ask to be reimbursed … the cost of X-ray films and other …plies he has paid for;

¶ Travel expenses, when consid…ble, may also be requested.

…exas M.D.'s Tell Public, 'Door's Always Open'

"The best medical care in the world … available to you regardless of your …bility to pay." That's the theme of … powerful series of newspaper ads …onsored recently by the Texas …edical Association and published … its component county societies. …y Texan who finds that the per…rmance doesn't live up to the …omise is urged to present his com…int to a grievance committee. …e societies assure him a full, fair, …d confidential investigation.

Pointing out that the doctor's door …s always open and that if a layman …eeds medical care, all he need do … ask for it, the ads all concen…rate on different aspects of one cen…al theme: Doctors aren't "out to …ouge" the public; their primary …oncern is to provide medical care …regardless of ability to pay."

Since most complaints result from …misunderstandings between patient and doctor, each of the Texas ads hammers home some facet of the truth that the general public may not be aware of. A typical excerpt, under the heading, "Your Doctor Suggests . . . ":

"1. Your doctor wants you to tell him when a fee, which is reasonable for others, is more than you can pay without depriving yourself . . . of other necessities.

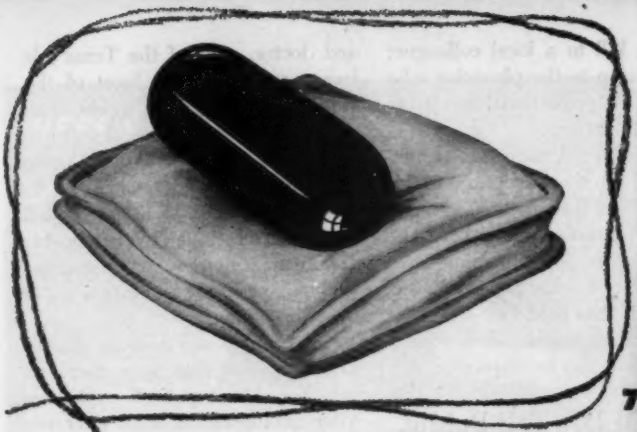
"2. Frankly and honestly discuss your situation with your doctor in advance. Don't put off explaining your circumstances until after you receive the doctor's bill. It isn't fair to either of you.

"3. Arrange now, while you are well, to have a family doctor . . . one who will know you and your financial circumstances . . . If you don't have a family doctor, let us help you find one.

"4. Arrange, while you are well, to cushion your budget against the economic shock of sudden illness. Ask your doctor about the many low-cost plans of voluntary health insurance. They cost but a few cents a day."

List Rules for Medical 'Hares and Hounds'

Dr. Watson would have loved it. In the old days he was always ready, at the drop of a hint, to abandon his practice and trot off after Sherlock Holmes, as the great British detective ferreted his way to the heart of some perplexing mystery. Dr. Wat-



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7½ gr. (0.5 Gm.) *BLUE* CAPSULES CHLORAL HYDRATE—Fellows

• DESIRABLE SLEEP lasting from five to eight hours, usually free from undesirable after-effects. Pulse and respiration are slowed in the same manner as in normal sleep. Reflexes are not abolished and the patient can be readily aroused. "CHLORAL HYDRATE produces a normal type of sleep, and is rarely followed by 'hangover'."[1]

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3¼ gr.

EXCRETION — Rapid and complete, therefore no depressant after-effects.[2-4]

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BIBLIOGRAPHY
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2. Robbins, H. B., et al: A Course in Practical Therapeutics (1943)
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son was never any help, but there's little evidence he was of much value to his patients either.

Lately, physicians all over England have been feeling like involuntary Dr. Watsons, and they're not amused. The National Health Service, with a red-hot mystery of its own, has pressed them into duty as sleuths.

The drama really started several years ago, when the N.H.S. reported that doctors' patient lists were "considerably inflated." In some areas there were, embarrassingly, more patients than people. A number of doctors had names on their lists (at a capitation fee of about £1 a year per name) but no patients to show for them.

Some people appeared to have got themselves on a number of lists. Others had moved away or died (carelessly neglecting to notify their doctors).

In time, the N.H.S. eliminated a vast number of names; most lists, it says, are now inflated by no more than from 1 to 3 per cent. But, determined to run down the last of the phantoms, it now asks the doctors themselves to join in the chase. Here are some of the ground rules recently furnished physicians, along with a list of each man's vanished patients:

¶ If a doctor feels himself still responsible for a missing patient, the N.H.S. will send a tracer letter to the patient's last known address.

¶ If he isn't sure whether he's responsible or not, the N.H.S. will do the same thing anyhow.

¶ If that doesn't produce results, the N.H.S. will search local electoral registers. After that it will call on housing authorities for help.

¶ Still lacking results, it will write to the doctor, asking him if there's anything new on the case.

¶ If he's still in the dark, the N.H.S. says it *may* "arrange a visit" by a member of the executive council's staff, but it doesn't say on whom.

¶ Then, if six months have gone by and no trace of the patient has been found, the N.H.S. says his name will be removed from the doctor's list—and the patient and practitioner will be notified accordingly.

'Medical Credit Rating' Called Perilous Phrase

Do you use phrases in your letters that may promote good collections but bad public relations? According to George Elder, president of the National Association of Medical-Dental Bureaus, some physicians unconsciously do just that with such joggers as "A good medical credit rating is a valuable asset in time of need" or "Protect your health and credit by prompt payment."

Professional collection agencies compound this error, Elder says, when they imply in their letters that they employ staffs of sharp-eyed investigators whose full time is spent probing the credit records, delin-

quent debts, and paying habits of patients.

Why is all this a mistake? Because it conflicts, he points out, with the pledge of the profession that no one shall lack medical care merely because of an inability to pay.

According to Elder, "the universal availability of medical care" is the strongest argument against socialized medicine. Yet "I fear that the force of this argument is being weakened by talk about such things as 'medical credit ratings' . . . It is no great step, in the mind of the general public, from a credit rating to a black list which will prevent people from getting new medical credit [and, in turn, medical care] until their last doctor bill is fully paid."

Says Personality Makes Big Difference Today

If a doctor is to get his head and shoulders above today's competition, he'd better develop a warm personal relationship with his patients; otherwise they may regard him as just an efficient robot among hundreds of others. This warning comes from Dr. R. J. Whitacre, president of the medical staff, Huron Road Hospital, East Cleveland, Ohio.

With the trend all toward efficiency and specialization, he says, 'a great many people think of physicians as highly efficient and indispensable machines, whose services

R. J. Whitacre

Are you a robot doctor?

are purchased at hospitals along with clean bedding and magic pills. You may smile at this, but it is the exact situation in many localities. A prominent surgeon in Cleveland did not conceal his disappointment recently when he commented, 'It is discouraging how uninterested people are in what doctor they are referred to.'"

The Old Army Game Ain't What It Used to Be

Paper work for Army doctors? It's a thing of the past, reports Maj. Werner Lehmann, who served in World War II and has been recalled to duty. There are still reams of reports to be made out, he writes to his colleagues in the San Diego (Calif.) medical society, but medi-

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1. Dixon, H. H., Dichel, H. A., Coen, R. A. Haugen, G. B. American Journal of Medical Sciences, 220, p. 23-29, July, 1950.

2. Berger, F. M., Schu R. P., Journal American M cal Association, p. 772 Vol. 137, No. 9, June 24, 3. ibid p. 772.

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cal officers are now spared the chore.

"All the paper work, all the clerical jobs, all the purely administrative tasks are now handled by the Medical Service Corps," says Major Lehmann. And, he adds, its personnel do a topnotch job.

"Nowadays," he continues, "the Army doctor is almost 100 per cent professionally employed, and he has less paper work than his civilian brother, who is constantly plagued by all sorts of insurance forms, tax returns, and letters of inquiry. There is no doubt in my mind that this is the greatest single improvement in the service since the last war."

What's in a Name? Well, Maybe a Capital Letter

Are you writing a medical paper, or planning one? Better come to a full stop before you type out the name of any drug, advises the Journal of the Medical Society of New Jersey. There's a chance that the name is somebody's private property, duly copyrighted or registered with the Patent Office, and that means you can't use it without indicating, in some way, that it's a trade-mark.

"In your daily conversation," says the journal, "you use many of these tradenames glibly . . . However, Parke Davis does own the word 'Adrenalin' and Smith, Kline and French have proprietary title to the word 'Benzedrine.' Butesin is made by Abbott Laboratories and nobody else." The journal admits to having printed an article that referred "to Butesin without indicating that it was a 'proper' name. We forgot. Abbott Laboratories didn't. We apologize."

There are, it points out, many common names that are *not* in the public domain. Therefore it's never wise to guess about a drug. "It's safe to assume that nobody owns the name 'alcohol'; and 'distilled water' is still in the public domain. But you never can tell. Pyrex is a trade-name and so is Vaseline (Chesebrough Manufacturing Company). It is easy to get confused between procaine (small 'p') and Novocaine (capital N—tradenamed by Winthrop) . . . If the name is a trademark or has been registered or copyrighted, be sure to indicate that in your manuscript."

How to indicate it? Well, you can use "a capital initial . . . Or you can write a little letter 'R' with a circle around it after or above the name . . . Or you can footnote it to the name of the manufacturing company . . . Or you can write the name of the company in parentheses immediately after the name of the drug."

To find out whether a product is trade-marked, the journal suggests looking it up in the Physicians' Desk Reference. Or, it concludes, if you'd rather skip the whole involved process, "you can confine your therapy to the use of caffeine, calcium and

curare, though that might limit your writing if not your practice. Probably the best bet is to ask your pharmacist. He's a good man to talk to now and then anyway."

Should Health Insurance Cover All Expenses?

After pondering one of the Federal Security Agency's latest statistical gambits—a study of U.S. voluntary accident and health insurance payments—B. B. Kendrick of the Life Insurance Association of America thought he smelled a rat. What started him sniffing was this statement by Commissioner Arthur Altmeyer of the Social Security Administration:

"Private insurance against sickness met about 10 per cent of the costs of sickness in 1950."

The trouble with this bald pronouncement, Kendrick has decided, is that it conceals a favorite propaganda weapon: The Big Implication. Altmeyer's statement, says Kendrick, implies "that the voluntary health insurance movement is of trivial worth in aiding the public to meet the costs of ill health"; therefore, perhaps, "compulsory health insurance . . . is necessary."

The commissioner's figures may be right, but they "are not valid as an argument for socialized medicine." What's more, Kendrick adds, they are "largely irrelevant to the purpose and aims of the voluntary health insurance movement." Reason: "The percentages compare health insurance benefits with the

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total costs of sickness rather than with the fraction of such costs which . . . should be met by insurance."

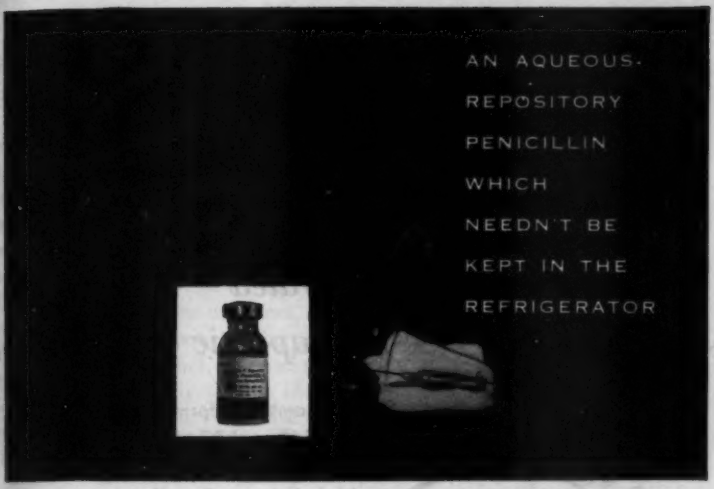
According to Kendrick, voluntary health insurance "cannot and should not seek to protect everyone against the full costs of every health service he may desire—from aspirin tablets and vitamin pills to private nurses and rest cures at expensive health resorts." He points out, too, that much of the nation's total health cost—which Commissioner Altmeyer seems to imply should be fully covered—stems from one-day illnesses, "against which insurance can hardly be considered essential."

Much needed to bring the subject into clearer focus, says Kendrick, is a study to determine desirable coverage. Though not certain of what such a study would show, he guesses "that not more than 30 to 50 per cent of the nation's total health costs might desirably be met by insurance."

Rules for Hamstringing A Medical Society

The Massachusetts Medical Society has written a prescription it hopes everyone will ignore. Here it is, condensed:

"Don't come to meetings—or, if you do, come late. If you don't attend, find fault with officers and members . . . Never accept an office, as it's easier to criticize than to do things. Nevertheless, get annoyed if not appointed to a committee . . . If asked by the chairman for an opinion, tell him you have nothing



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to say. Afterward, tell everyone how things should have been done . . . Do nothing more than is absolutely necessary. But when others roll up their sleeves to help things along, howl that the society is run by a clique."

Says Would-Be Big Shots Choke on Medical Bills

When disputes arise over fees, patients are right about half the time, doctors the other half. So concludes the grievance committee of the Fulton County (Ga.) Medical Society after considering fifteen complaints, thirteen of them alleging overcharges.

"The biggest fault of patients," reports Dr. Walter W. Daniel, the committee chairman last year, "is that they often try to impress the doctor by wearing their best clothes and trying to make him think they are very prosperous. Then they're surprised when they get his bill. Only rarely does a patient try to look poor."

Writer Deplores Patient Gouging by Hospitals

Some hospitals deliberately pad their patients' bills, says Albert Q. Maisel in the April issue of American magazine; so he warns the public to show due care in picking an institution. The bill inflating is done, he says, by overcharging for auxiliary services—radiology, pathology, drugs and medication, blood transfusions, etc.—and by creating new "extras" wherever possible.

Basing his report on a personal investigation of hospitals, Maisel quotes this warning from President John W. Cline of the A.M.A.: "The public will no more tolerate what it considers dollar-conscious money grabbing on the part of the hospital than it will exorbitant fees on the part of the physician."

Many hospitals are in a deplorable financial condition, the writer concedes, chiefly because of the heavy cost of indigent care. But, he says, that comes from their refusal to insist that welfare agencies, public and private, foot the full bill for charity cases. Instead, says Maisel, they try to make up the losses by overcharging paying patients, who are thus taxed indirectly for public welfare work without their knowledge.

The result, he says, is "skyrocketing room rates, poorer service, unforeseen and staggering 'extras,' a final bill that [makes] even a minor operation a financial disaster."

All this exists in what he sees as a welter of deception. For instance, take room rates. The quoted room rate is generally a false front, Maisel asserts. And he repeats the words of Dr. Lucius R. Wilson, director of the Episcopal Hospital, Philadelphia: "It has been the long-standing custom of hospitals to increase charges for auxiliary services and keep room charges at a low figure,

so the daily rate, when quoted, will not *seem* exorbitant."

In recent years, room rates have gone up, but patients have accepted the increase as part of the general rise in living costs. What they don't realize, says Maisel, is that auxiliary charges have increased beyond all reason. He cites as an example "a recent report of charges for appendectomies" at Herrick Hospital, Berkeley, Calif.:

"Semi-private room charges there in 1941 averaged $6.30 per day. By 1948, they had been increased to an average of $12.50—almost 100 per cent. But meanwhile, the daily cost of extras had jumped by more than 400 per cent: from $4.13 a day in 1941 to $18.10 a day in 1948." The result, he says, is a quoted room rate of $12.50 a day but an average daily billing of $30.60.

Another big undercover money-maker, the author tells his readers, is the X-ray department. Says he: "The administrator of one medium-sized hospital in the Chicago area, proudly displaying the gleaming new machines with which he had just re-equipped his radiology labs, boasted to me, 'We net 50 per cent on our X-rays; more than $50,000 a year.'"

A recent Detroit survey, says Maisel, has shown "how remunerative these so-called auxiliary services can become." Take, for instance, charges for medicine. The survey found that the purchase, preparation, and administration of drugs made up 3.5 per cent of the hospitals' expenses, but their sale brought

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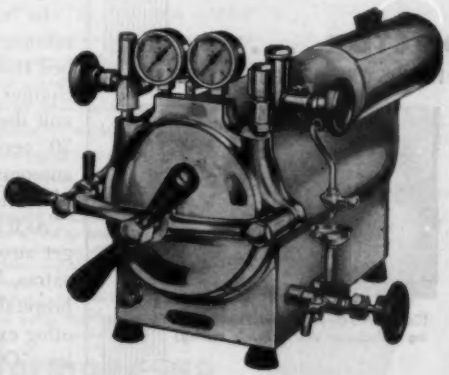

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in more than 10.7 per cent of income.

In this connection, the article cites the so-called "miracle drugs." It declares that when widespread publicity created a demand for them, the hospitals jacked up the price, and many have neglected to reduce it even though the drugs now cost only a fraction of what they once did.

"I asked 20 hospital administrators, from institutions all over the country," says Maisel, "to tell me the charge they make for the injection of a 100,000-unit dose of penicillin. Their figures ranged from a low of $1 to a high of $2.85. The average charge was $1.75. Yet hospitals can purchase their penicillin at a cost of only 22 cents for such a dose . . ."

In "vivid contrast" to most institutions, says the author, is the 250-bed Hackensack (N.J.) Hospital. It charges only 35 cents for a 100,000-unit dose of penicillin. It gets only 50 cents for 250 milligrams of aureomycin; other hospitals charge as much as $2.50 for that amount.

As if it weren't bad enough just to get atrocious prices for *necessary* extras, Maisel maintains that many hospitals are now deliberately *creating* extras as a profit-building policy: "One hospital in the New York area, for example, formerly employed nurse-anesthetists working directly under the guidance of the surgeons . . . It billed its patients an average of $15 . . . for anesthesia and made a sizable profit on such charges.

[Turn page

"Now, however, this institution has granted a monopoly to 3 physician-anesthetists. They work as a partnership group. Thus neither patients nor their surgeons have anything to say about their choice of anesthesia specialists. But, after every operation, the patient finds *two* anesthesia items on his bill. The hospital still charges $15 to cover the use of its equipment . . . but now it calls it 'anesthesia service.' And the doctor anesthetists send their own bills, as consultants, running from a minimum of $25 to $100 and more."

This hospital, Maisel says, makes as much on anesthesia as it ever did, any increase in costs being more than offset by a saving in salaries; but the patient now pays two or three times as much. And, adds the writer, "the three monopolists are taking in over $40,000 a year."

According to the American magazine article, there are still other types of "monopolists": Typical is the blood-tranfusion specialist, who pays the hospital a high rent for office and laboratory space he never uses, and in return gets exclusive rights to perform transfusions. All preliminary work—typing, operating the blood bank, sterilizing the needle, preparing the patient—is done by technicians. The specialist merely inserts the needle.

Where does such a policy lead? Maisel quotes the answer of John H. Hayes, superintendent of Lenox Hill Hospital, New York:

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tient to get bills from the hospital, the surgeon, the anesthetist, the medical consultant, the radiologist, the pathologist, the cardiologist, the physical-therapist . . . and maybe three from his special nurses."

When physicians themselves resent this sort of thing, they can take efficient action against it, according to one of the author's stories. In a certain New England hospital, he says, "the chairman of the board of trustees wrote medical staff members urging them to refer more patients to various departments for special and, according to some interpretations, unnecessary services. When word of this letter got out, local medical authorities raised a howl and the tactless hospital trustee formally withdrew his announced policy."

British Health Service Swamped by Lawsuits

Malpractice suits against the National Health Service are springing up all over England. In fact, says Dr. T.N.A. Jeffcoate, professor of obstetrics at the University of Liverpool, "These claims have become so large that the government has set up a special fund to meet payments decreed by juries."

Dr. Jeffcoate attributes this "epidemic" to the fact that the complainants seem to feel that the government has plenty of money. Back in the days of private practice, he says, they might have been "deterred by fears of bankrupting a particular small hospital."

I'm voting for the man who's against waste like this!

These examples of federal waste and inefficiency were unearthed by the bipartisan Hoover Commission:

- **One federal agency had a 93-year supply of fluorescent bulbs . . . another had loose-leaf binders to last 247 years.**
- **The Veterans Administration employs 4 times the manpower private insurance companies do, yet takes 5 times as long to pay claims.**
- **The Bureau of Reclamation and the Army Corps of Engineers, ran surveys for a dam in Idaho. Each survey cost $250,000—only *one* was needed!**
- **"Hidden" Subsidies to airlines add millions a year to the Post Office deficit.**

During 1951 Congress voted to raise the federal budget by 70%. But little attention was given to the economical management of this huge budget. Important legislation recommended in the bipartisan Hoover Report was passed over.

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Send today for a copy of our FREE booklet, "Saving Dollars." It gives all the facts behind the Hoover Report and shows what must be done to keep our country in fighting trim. Write Box 659, Philadelphia. Tell your friends about it—*and write your Congressman!*

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Memo from the Publisher

• In the last ten years, some 60,000 new doctors have entered the medical profession. Not long after receiving their M.D. degrees, most of them have become regular readers of MEDICAL ECONOMICS.

This steady influx of new readers accounts for something you may have noticed about the magazine: its *planned repetition* of certain basic editorial topics.

Take one of our most requested back articles: "A Time-Tried Senior-Junior Partnership." We have actually published it four times, in essence—the last time in 1948. Yet the demand for this sort of guidance seems to be increasing, especially among young M.D.'s. So in a few more years, and after suitable revisions, we'll probably publish it again.

Or take "Letters to a Doctor's Secretary," a series we first published ten years ago. We're running it again right now—mainly because a good many of those 60,000 new doctors have indicated they need some such office-management aid.

Most editors have a horror of repeating themselves. We must, and do, guard against this prejudice as against any other editorial bias.

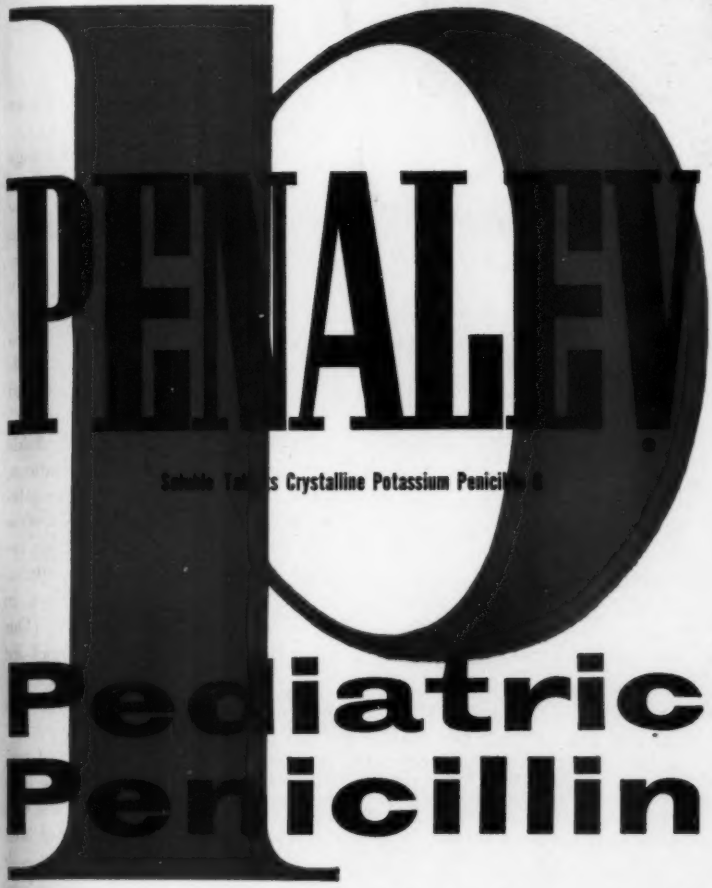
"One of the greatest shortcomings of . . . business publications," an authority has said, "is that they DON'T repeat themselves. They go too much on the theory that every reader has read everything they have previously published. They forget that the very lifeblood of a publication is its influx of new readers. And that the new readers need a certain amount of indoctrination."

That's why, in such basic fields as legal medicine, patient relations, insurance, and taxes, we deliberately repeat ourselves at times. One article a month, on the average, reopens a subject treated in MEDICAL ECONOMICS ten years earlier—or, in special cases, more recently. (Our most frequent repeat: a check-list of professional income-tax deductions, published shortly before tax time each year.)

None of this means that we simply reprint an earlier article verbatim. Instead, we take on the task of revising it, updating it, and adding good new material. The result is almost sure to be a more helpful piece than the one we started with.

Do old readers mind such repetition? On the contrary, many of them ask for it. In their business affairs, as in medical science, they've learned the value of refresher courses.

—LANSING CHAPMAN



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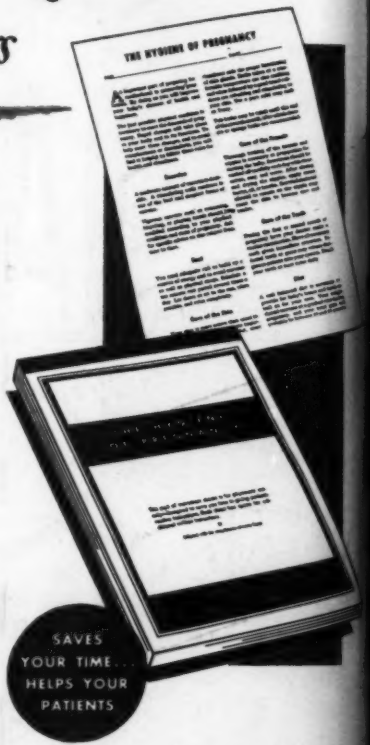

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